



FINANCIAL POLICY

It is the policy of King Family Medicine that all fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

Insurance coverage is considered by King Family Medicine as an agreement between the patient, the insurance company and the employer, where applicable. King Family Medicine is not a party to that Agreement and as a result is not bound by any of the Covenants, limitations, or restrictions of that policy.

As a service to our patients, we will file insurance claims for hospital, and clinic related charges. Itemized bills will be provided to you for office services upon request. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided.

Charges for services not covered by insurance are due when a patient statement is received unless specific arrangements have been made for an extension of time. If you have special needs, contact our Patient Accounts Department. You are responsible for payment of services not paid in whole or in part by your insurance.

Statements showing the status of your account are mailed monthly. Please retain all your statements as itemized transactions are not repeated. If re-itemization is requested later, a service charge will be made.

King Family Medicine is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact our office as soon as you receive our statement. Special arrangements can be made in which the patient agrees to pay at regular intervals an amount based on his or her financial resources.

Accounts which are not paid within a reasonable period of time, and for which not special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statement, I agree to the terms set forth.

Signature: _____

Date: _____

**AUTHORIZATION TO RELEASE INFORMATION
AND ASSIGNMENT OF BENEFITS**

I, the patient or guarantor/guardian, certify that the information on this form is true to the best of my knowledge. I hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations who/which will be providing subsequent monitoring, care or treatment in connection with care provided by any King Family Medicine clinic. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I understand that any billing or financial information will be available to King Family Medicine. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to the physician and/or clinic. I further agree that a photocopy of this document is to be considered as valid as an original.

Patient Signature: _____

Date: _____

Guarantor/Guardian Signature: _____

Date: _____