

Authorization to Bill Insurance Company and Acknowledgment of Billing Policy

If you have medical insurance, our goal is to help you achieve the maximum benefits due you. In order to achieve this goal, we need your assistance and understanding regarding our payment policy. **PAYMENT IS DUE AT THE TIME OF SERVICE.** We accept cash, check, Visa and MasterCard. If your insurance is one with which we participate, we will file your insurance for you. You are, however, expected to pay your percentage due, co-payment, or any deductible you have not met, at the time of service. We will try to answer any questions regarding your insurance, but understanding that your own insurance benefits are your responsibility. As medical providers our relationship is with you, not your insurance company and all charges are YOUR responsibility.

I have received and understand the billing policy, I understand that payment is my responsibility. I have also reviewed the past due accounts policy and understand it.

For **Medicare Patients:** I request that payment of authorized Medicare benefits be made to me on my behalf, or to Trinity Medical Associates, LLC for any services furnished. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents, any information needed to determine these benefits of these benefits of these benefits payable for relate services. I also request that payment for authorized Medigap benefits be made on my behalf to Trinity Medical Associates, LLC for services provided. I authorize any holder of medical information about me to release to my Medigap insurer and any information needed to determine these benefits. I understand that I do not need to provide my authorization will cause Medicare payment information to cross over automatically.

Beneficiary Signature _____ date __/__/__-

For **Non-Medicare Patients:** I authorize release of any medical information necessary to process this claim and related claims. I request that payment of authorized benefits be made either to me or on my behalf to Trinity Medical Associates, LLC for any services furnished to me.

_____ date __/__/__

All Patients: I agree to pay all charges for myself and members of my family, as applicable promptly upon presentation of. Charges as shown by statements are agreed to be correct unless protested in writing within 30 days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

Signed _____ Date ____/____/____