CAPE MEDICAL GROUP

Patient Name (print): _____ **Date of Birth:** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE THIS PHYSICIAN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER, (OR, IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION). A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER MY INSURANCE CARRIER OR ME AT ANY TIME IN WRITING.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO THIS PHYSICIAN FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

FINANCIAL AGREEMENT

I HEREBY ASSUME FINANCIAL RESPONSIBILITY FOR AND AGREE TO MAKE PAYMENT IN FULL TO **CAPE MEDICAL GROUP** FOR ALL CHARGES FOR SERVICES OR MEDICAL SUPPLIES FURNISHED THE ABOVE- NAMED PATIENT NOT OTHERWISE AUTHORIZED OR PAID BY MY INSURANCE CARRIER. PAYMENT IS TO BE MADE WITHIN 30 DAYS AS STATEMENTS ARE PRESENTED WITH SETTLEMENT IN FULL, OR PAYMENT ARRANGEMENTS TO BE MADE COMPLETE TO THE BEST OF MY KNOWLEDGE, AND FURTHER AUTHORIZE **CAPE MEDICAL GROUP** TO INVESTIGATE ANY AND ALL FINANCIAL INFORMATION GIVEN CONCERNING THIS OR RELATED CLAIMS.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

NO SHOW/LATE CANCELLATION/RETURNED CHECK FEES

I ACKNOWLEDGE THAT I MAY BE CHARGED A FEE OF $50.00 FOR MISSED APPOINTMENTS AND/OR APPOINTMENTS CANCELED LESS THAN 24 HOURS PRIOR. I ACKNOWLEDGE THAT I MAY BE CHARGED $25 FOR RETURNED CHECKS. I ACKNOWLEDGE THAT I WILL BE CHARGED $150 FOR A MISSED IN-OFFICE PROCEDURE AND $250 FOR A MISSED SURGICAL PROCEDURE.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

COLLECTION FEES

SHOULD THE TREATING PHYSICIAN, REFER MY ACCOUNT TO A COLLECTION AGENCY AND/OR ATTORNEY FOR COLLECTION, I AGREE TO PAY ALL COLLECTION COSTS, INCLUDING BUT NOT LIMITED TO COURT COSTS AND ATTORNEY FEES OF 25 PERCENT OF MY BILL. I UNDERSTAND THAT ALL DELINQUENT ACCOUNTS SHALL BEAR INTEREST AT THE RATE OF 12 PERCENT PER ANNUM.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

FOR MEDICARE PART B PATIENTS ONLY

I UNDERSTAND THAT IN CERTAIN CIRCUMSTANCES MEDICARE MAY DECIDE THAT APPROPRIATE MEDICAL SERVICES ARE NOT MEDICALLY REASONABLE OR NECESSARY UNDER THE MEDICARE LAW. SINCE MEDICARE MAY DENY PAYMENT FOR THESE SERVICES, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF THESE CHARGES.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE