Montgomery Family Medicine
8190 Seaton Place ◆ PO Box 240369
Montgomery, AL 36124

FINANCIAL POLICY

I AUTHORIZE that payment of medical benefits be made to Montgomery Family Medicine on any claim submitted for services furnished to me by Montgomery Family Medicine and Staff.

I AGREE that the fees charged by Montgomery Family Medicine are lawful debts and I promise to pay said fees including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

I UNDERSTAND that any money received from my insurance company or health plan over and above my indebtedness will be refunded to me when my bill is paid in full.

I UNDERSTAND that I am financially responsible to Montgomery Family Medicine for charges not covered by my policy or health plan.

I UNDERSTAND that Montgomery Family Medicine's relationship is with me, not my insurance company or health plan.

I UNDERSTAND my insurance policy or health plan is an agreement between my insurance company or health plan and me. I am responsible for knowing the coverage provided. All charges incurred are my responsibility.

I AGREE to bring my insurance card to every visit, pay any required co-payment at each visit, know the coverage and benefits of my policy or plan, and keep Montgomery Family Medicine informed of any changes.

I UNDERSTAND that there will be a $20.00 administration fee charged for every visit where a co-payment is due and not paid, and I UNDERSTAND that Montgomery Family Medicine reserves the right to charge up to $50.00 for appointments not kept and not canceled 24 hours in advance. I UNDERSTAND that these fees and any other charges or fees are subject to change without notice.

I UNDERSTAND that accounts more then 90 days past due may be turned over to a collection agency by Montgomery Family Medicine with or without notice to me and additional fees will be incurred.

I have read, understand and agree to the provisions of this Financial Policy.

_____

Name of Patient Signature of Patient or Person Financially Responsible Date

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER

Beneficiary Name:_____ Health Insurance #_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Montgomery Family Medicine for any services furnished to me by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature:_____ Date_____