

## PATIENT CONSENT & ASSIGNMENT

PATIENT NAME: \_\_\_\_\_

***Please Read Before Signing***

**MEDICARE**

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment for services rendered for the condition to which I have been seen. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

**BLUE CROSS/BLUE SHIELD**

I understand the charge of a non-participating physician (to which I may be referred) may exceed the Blue Cross/Blue Shield payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process any and all claims for services rendered. For charges of a **participating provider**, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

**LEGAL ASSIGNMENT**

The undersigned expressly agrees that if, upon default, this matter is referred to an attorney for collection, the undersigned agrees to pay an attorney's fee (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

**INSURANCE ASSIGNMENT**

I authorize and assign payment directly to the physician(s) involved in my treatment and authorize release of medical information necessary to process the claim(s). I further understand I am financially responsible for charges **not covered** by my insurance.

**MANAGED CARE**

I understand that, without an authorization/referral form from my HMO/IPA/PPO, I will be financially responsible for any and all charges I incur.

The Hoffberger Breast Center at Mercy is an outpatient department of Mercy Medical Center. Accordingly, you will receive two bills for your appointment in the Center. You will receive a physician services bill from the physician group and an outpatient clinic bill from Mercy. Together, the two bills represent charges incurred during your visit to the Center and we provide this notice to help avoid confusion when you receive two separate bills.

Depending on your insurance coverage, you may be responsible for some or all of both bills. All charges are billed to the patient's insurance company to determine the amount of patient responsibility. If in doubt, please contact your insurance carrier to determine the co-pay, deductible and/or coinsurance amounts.

Thank you.

**I have read and understand this billing notice:**

\_\_\_\_\_  
 Patient Name - Printed

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date of Signature