Please read carefully before completing. If you have any questions, please ask a staff member.

AUTHORIZATION FOR RELEASE OF INFORMATION TO MY INSURANCE CARRIER(S)

I authorize release of medical information necessary to process this (these) insurance claim(s) and permit a photocopy of this to be used in place of this original document for all federal, state, commercial, compensation or liability insurance claims.

Signature: _____ **Date:** _____

AUTHORIZATION TO ASSIGN BENEFITS TO NEIL JULIE MD PA

I certify that information provided relative to injury, illness, and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim or legal/court settlement to be assigned to _____ **Neil Julie MD PA** to the extent that their charges are paid in full.

Signature: _____ **Date:** _____

MEDICARE and/or MEDIGAP Authorization and Assignment of Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by **Neil Julie MD PA**. I authorize any holder of medical information about me to release to the Social Security Administration and Center of Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare and/or Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for my treatment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is in effect until I choose to revoke it in writing.

HIC Number: _____

Signature: _____ **Date:** _____

FINANCIAL RESPONSIBILITY

Patients are responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our practice for seeing the patient out of network. Most managed care insurance carriers require a written referral from a primary care physician ***in advance of service*** (office visits, surgery and diagnostic tests). Patients or their legal representatives are responsible for (1) obtaining physician referrals, (2) contacting their insurance carrier to verify benefits in advance of service and (3) confirming the practice's participation with their plan. **Co-payments, if required by your plan, are due on each visit.** The practice reserves the right to reschedule patients who meet their appointments without a valid referral. In addition, the practice reserves the right to charge for missed appointments unless I notify the practice no less than 24 hours in advance.

As a courtesy, a claim will be filed with *my* insurance carrier (based on the information provided by me); however, I understand that I am responsible for all charges resulting from treatment provided by **Neil Julie MD PA**, unless the services are deemed "paid in full" as a result of a contractual agreement between _____ **Neil Julie MD PA** and my insurer. I understand that **Neil Julie MD PA** cannot accept responsibility for collecting or negotiating settlement on any disputed (1) worker's compensation claim (2) accidental injury/illness liability claim, or (3) claim where patient is/will be represented by an attorney, and/or (4) claim to be settled in a court of law. Should any insurance payment be made directly to me for monies due on my account, I agree to immediately pay these funds to **Neil Julie MD PA**. I understand that if I default in payment of my account and the outstanding balance is turned over for collection, I may be responsible for attorney fees and collection costs.

We accept cash, money orders, personal checks, Visa, or MasterCard or Discover. Returned checks will be subject to the additional penalties as determined under the laws of the state of Maryland. You have the right to dispute or clarify any billing issues by contacting our billing department at (301)987-0020 ext 207.

Signature: _____ **Date:** _____

Patient Information Update form- 2004	Account # _____ Date computer updated: _____ Employee. Initials _____