FINANCIAL RESPONISBILITY STATEMENT / RELEASE OF INFORMATION AUTHORIZATION

MEDICARE PATIENTS ONLY

I, _____, request that payment of authorized Medicare benefits be made on my behalf directly to South Haven Family Physicians, P.C. for any services furnished to me by its physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or any benefits payable for related services. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Signature Date

ALL PATIENTS

I authorize South Haven Family Physicians, P.C., to furnish information to my insurance carrier, concerning the illness or medical treatment of my dependents and myself. I hereby assign to South Haven Family Physicians, P.C. all insurance payments for medical services rendered to myself or my dependents, except for those services for which I have already paid prior to the filing of the insurance claim.

_____ _____

Signature Date

I acknowledge responsibility for payment of all medical bills incurred by myself and or dependents regardless of any insurance that I may have to assist me in this responsibility. I understand that payment is due at the conclusion of my visit. If for any reason this account should become delinquent, I agree to pay for all collection and legal fees.

_____ _____

Signature Date