Please read and sign the applicable statements regarding our insurance and payment policies.

Assignment and Release

I, the undersigned have insurance coverage with (insurance company name)

_____

and assign directly Petoskey Gynecology & Infertility and its medical providers all medical benefits, if any, otherwise payable to me for medical services rendered.

_____ _____

signature of insured / guardian date

Medicare Authorization (if you have secondary insurance, please sign above also)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Petoskey Gynecology & Infertility and its medical providers for any services furnished me by its providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed on HCFA-1500 form, or elsewhere in other approved claim forms or electronically submitted claims. My signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

_____ _____

beneficiary signature date

Payment Agreement

I understand that Petoskey Gynecology & Infertility will submit to my insurance company the information necessary to secure payment of benefits for covered services. I understand that this will require accurate and complete information from me. If the information I provide is deficient in a way that prevents payment of insurance benefits, I agree to assume full responsibility for payment.
I also understand that I am financially responsible for all charges including deductibles, co-payments, and services not covered by my insurance contract, and agree to timely payment of my obligations. If uninsured, I agree to full payment at the time of services.

_____ _____

signature of patient/ guardian date