SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT
Andrew P. Giacobbe, M.D.

Patient Name: _____

PAYMENT POLICY:

HMO, PPO or managed care patients: You will be responsible for paying your annual deductible, co-payments and charges for any noncovered or cosmetic procedures.

Commercial Insurance Patients: Patients who are covered by private, commercial plans in which Dr. Giacobbe is not a provider, our office will bill your insurance company. The entire unpaid balance left after payment from your insurance will be billed to you.

Divorced Parents: The parent bringing the child to our facility will be responsible for required co-payments, deductibles, etc. at the time of visit.

FINANCIAL AGREEMENT:

I agree that in return for the services provided to the patient by Andrew P. Giacobbe, M.D., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Andrew P. Giacobbe, M.D. for payment.

If an account is sent to an attorney or collection agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court.

I understand and agree that if my account is delinquent, I may be charged a service fee.

If co-payments and/or deductibles are required by my insurance company or health plan, I agree to pay them to Andrew P. Giacobbe, M.D.

I will notify this office of any changes in insurance and will pay in full for services denied due to no coverage at the time of service.

Returned checks will result in a $20.00 returned check fee added to the outstanding balance on my account.

It is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies when requested to facilitate your payment.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION.

I hereby authorize my insurance benefits to be paid directly to Andrew P. Giacobbe, M.D. realizing I am responsible to pay all non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

I request that payment of authorized Medicare benefits and any other insurance benefits be made on my behalf to Andrew P. Giacobbe, M.D. for any services furnished me by Andrew P. Giacobbe, M.D. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

Beneficiary or Guardian Signature:_____
Date:_____