ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that all professional services rendered will bill billed to my insurance as a courtesy and that I am at all times financially responsible to Emmitsburg Osteopathic Primary Care Center, Inc. for any charges not covered by health care benefits. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received. I understand that co-payments and deductibles are due at the time services are rendered. **Post-dated checks will not be accepted. We do not second party bill.**

I further understand that Emmitsburg Osteopathic Primary Care Center, Inc. reserves the right to reschedule an appointment that is non-urgent if I am the guarantor for an account that is over 90 days past due and I am unprepared to make full payment or agree on a payment plan on the date that I present at the office for services.

Assignment of Benefits

I hereby assign all medical benefits to Emmitsburg Osteopathic Primary Care Center, Inc., for which I am entitled. In addition, I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Emmitsburg Osteopathic Primary Care Center, Inc., for all covered medical services and supplies provided to me during all courses of treatment and care *(subsequent and continuing)* provided by the medical staff at Emmitsburg Osteopathic Primary Care Center, Inc. I understand and agree that this Assignment of Benefits will constitute a continuing authorization, maintained on file with Emmitsburg Osteopathic Primary Care Center, Inc. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Emmitsburg Osteopathic Primary Care Center, Inc, its medical providers, billing agency and staff to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) process insurance claims generated in the course of examination or treatment; and 3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I authorize contact with appropriate family members for medical claims management and payment responsibility purposes while limiting disclosure of protected health information to a minimum.

I have requested medical services from Dr. Bonita Krempel-Portier on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

** Signature below certifies that all information provided to Provider by the undersigned or patient, including any information in connection with applying for payment under title XVIII of the Social Security Ace, is true and accurate in all respects.*

I have read and have a full understanding of the Assignment of Benefits of Emmitsburg Osteopathic Primary Care Center, Inc.

________________________________ ____________________

Patient/Responsible Party Signature Date

________________________________ ____________________

Witness Date