PATIENT FINANCIAL RESPONSIBILTIY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
   - Co-payments are due at the time of service.
   - In the event that my health plan determines a service to be "not payable, I will be responsible for the complete charge and agree to pay the costs of all services provided
   - I understand that if I do not notify the office and miss my appointment, I will be charged a "no show" fee of $25
   - If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to Grace Internal Medicine on my behalf for medical services provided.

3. **AUTHORIZATION TO RELEASE RECORDS**
   I hereby authorize Grace Internal Medicine to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider(s).

4. **MEDICARE REQUEST FOR PAYMENT**
   I request payment of authorized Medicare benefits for me or on my behalf of any services furnished to me by or in connection with Grace Internal Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient Name: _____ Date: _____

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Signature of Patient, Authorized Representative, or responsible person Relationship to patient

Grace Internal Medicine, LLC