Consultants In Internal Medicine, P.C.

FINANCIAL RESPONSIBILITY AGREEMENT

Some insurance companies do not cover certain procedures that may be requested or required by the patient or doctor. In the event this occurs, the patient becomes responsible for any charges incurred. ***It is the patient's responsibility to understand what is and what isn't a covered benefit under their insurance policy.*** The following is a list of the services that are **not** always covered:

* **Complete physical exams and well woman exams**
* **Screening examinations and test**
* **Some immunizations and injections**
* **Weight Management**
* **Removal of moles, warts, and skin tags**
* **School, sports, and adoption physicals**
* **Motor Vehicle Accidents- WE DO NOT accept third party payers. These visits are NOT processed through your medical insurance. We will provide bills/receipts for the patient to give to their automobile insurance company.**
* **TMJ (Temporomandibular Joint Disorder) is not covered by most medical plans**

***If I no show or cancel less than 24 hours prior to my appointment, I will be responsible for a charge of $40.00.*

I have read the above statement and understand it is my responsibility to know my insurance benefits. In the event a service is not covered, I agree to pay for all charges for the services rendered. If my account is placed with a collection agency I understand I will be responsible for all legal and collection fees.

I authorize direct payment and assign any insurance benefits otherwise payable to the patient to Consultants In Internal Medicine, P.C.

AUTHORIZATION TO RELEASE INFORMATION

I agree that to the extent necessary to determine liability for payment and to obtain reimbursment CIM may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable for all or any of CIM's charges including but not limited to insurance companies, health care service plans, workers compensation carriers, the patient's employer, and utilization review monitoring organizations.

Signature: **X**_____ Date:_____.

Patient Name:_____.