Blackhawk
MEDICAL GROUP

Authorization & Financial Agreement

Assignment of Benefits

I certify that my insurance coverage is correct as I have reported it to Blackhawk Medical Group. If at any time my insurance changes, I will notify the practice. I hereby authorize Blackhawk Medical Group to submit claims on my behalf for services rendered by any and all providers affiliated with this practice, and request that payment from my insurance company be made directly to Blackhawk Medical Group.

Authorization to Release Information

I authorize the release of any necessary information to my insurance carrier regarding the services provided by Blackhawk Medical Group. I permit a copy of this authorization to be used in place of any previous documents and understand it is valid until revoked by me in writing.

Financial Responsibility

- I agree to pay all self-pay charges, co-payments and deductibles at the time of service.
  - A **$10.00 Fee for Non-Payment of Co-Pays/Deductibles** will be charged in addition to my co-pay if I am unable to pay my co-pay at the time of service.
- I agree to provide my current insurance ID at every appointment, if requested.
  - A **$15.00 Re-Bill Insurance Fee** will be charged if I provide Blackhawk Medical Group with incorrect insurance information or fail to update my insurance prior to receiving services.
- I understand that nothing herein relieves me of the primary responsibility to pay for medical services provided. My insurance policy is an agreement between myself and my insurance company and I am responsible for understanding and obtaining coverage information.
- I accept responsibility for all charges for this or subsequent treatment; exempt are work related illnesses and/or injuries which have been authorized by my employer prior to the actual appointment.
- I agree that all bills are due when rendered and I agree to pay upon receipt. I realize that any collection efforts add unnecessarily to the cost of my care.
- I am willing to work with the office and my insurance company as necessary or requested, to assure timely processing of claims submitted on my behalf.
- In the event that my account shall be referred to collection, I agree to pay and be responsible for the amount of such bill together with any and all collection costs.
- A **$35.00 RETURNED CHECK Fee** will be charged to my account for all Non-Sufficient Fund checks returned from the bank.

No Show and Cancellation Policy

We sincerely request that 24-hour notice when cancelling or rescheduling an appointment.

- A **$35.00 NO SHOW/LATE CANCELLATION Fee** will be charged for all failed/late cancellations for standard office visits (15 minute appointments)
- A **$75.00 NO SHOW/LATE CANCELLATION Fee** will be charged for all physicals and extended visits not cancelled more than 24 hours in advance. (30 minute or longer time slots.)

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Signature of Patient or Legal Guardian/Guarantor Date