Cardio-Thoracic & Vascular Surgical Associates
INFIRMARY HEALTH

IMC-Patient Responsibility Consent Form

Patient Last Name	Patient First Name	___/___/___ Date of Birth
Primary Insurance	Secondary Insurance	FOR OFFICE USE: ______ MRN

Assignment of Benefits

I request that payment of authorized Medicare and/or Medicaid benefits to be made on my behalf for services in or by the Clinic, shall be made to the Clinic, and I specifically assign such benefits to the Clinic. If applicable, I hereby assign and authorize payment directly to the Clinic of all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled.

Release of Information

I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits or related services.

Financial Responsibility

I understand that I am responsible for all charges not paid by my insurance plan except those amounts that the Clinic is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible, the Clinic may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by the Clinic as a legal and lawful debt and agree to pay such fee if charged.

Telephone and Alternative Communication Consent

I understand the Clinic or its agents may use pre-recorded/artificial voice messages and or/auto-dialing devices to remind me about appointments or notify me of other information and I expressly consent to the Clinic or its agents use of any number associated with my account including any wireless number. I also authorize the Clinic or its agents to contact me at any number associated with my account, including wireless numbers, including contact by means of pre-recorded or artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account. I also authorize the Clinic to communicate with me using any email address I provide to the Clinic.

No Show Appointments

I understand when I make an appointment, time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify the Clinic no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand the Clinic has the right to charge me a no-show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged.

Minors

I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

Patient (or Responsible Party) Signature	___/___/___ Date

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