INSURANCE AGREEMENT DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

I/We hereby name the Doctor(s) and/or Medical Practice given below, hereafter referred to as DOCTOR, as my/our assignee. I/We instruct my/our health care benefits plan provider (i.e.; insurance company, HMO, employer, union or government-run health plan), hereafter referred to as the PLAN, to pay the DOCTOR directly for all professional and medical services provided. Payment should be made by means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed directly to the DOCTOR: **Podiatry Associates of IN, P.C. 5471 Georgetown Rd STE C, Indianapolis, IN 46254**

Sandra R. Raynor, DPM **Angela L. Glynn, DPM** **Tracy F. Warner, DPM** **Elizabeth A. Vulanich, DPM** **Tarick I. Abdo, DPM**
Daniel S. Miller, DPM **Brad S. Legge, DPM** **Timothy D. Howard, DPM** **Cathy O. Coker, DPM** **Amanda M. Vujovich, DPM**
Mieasha H. Barksdale, DPM **Khawar Z. Malik, DPM** **Richard C. Harris III, DPM** **Alaa N. Mansour, DPM**

Or if my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct the PLAN to make out all checks payable to me/us and mail the payments to me/us in care of the DOCTOR as given directly above.

THIS IS A DIRECT ASSIGNMENT OF MY/OUR RIGHTS AND BENEFITS UNDER THIS POLICY.

I/We grant the DOCTOR a limited Power of Attorney to sign my/our name(s) in order to deposit and negotiate any payment received from the PLAN and apply the funds received toward my/our outstanding balance. These payments will not exceed my/our indebtedness to the above designated DOCTOR. I/We agree to promptly pay any remaining balance due on all professional and medical service charges over and above payment(s) from the PLAN. This assignment shall remain in effect until cancelled in writing by the DOCTOR.

A photocopy of this agreement, or a electronic facsimile thereof, shall be considered as effective as the original.

I/We understand that personal information about me/us will be needed by the DOCTOR and the PLAN to determine and communicate what services or benefits are covered by the PLAN, and to submit or process a claim for payment on service rendered and for the DOCTOR to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I/we give to the DOCTOR, the PLAN, the Centers for Medicare & Medicaid Services (CMS), their agents, and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing and collection information.

Patient Name **Signature of Policy holder** **Date**

Patient DOB **Signature of Patient (if other than Policyholder)** **Date**

FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT & INFORMATION RELEASE

The Responsible Parties whose signatures appear below agree as follows:

The Doctor(s), Associates Doctor(s), and staff of the Medical Practice, named above and hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.

DOCTOR is authorized to collect, use and exchange *individually identifiable health information* (IIHI) consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing restrictions on its' future use. DOCTOR is not obliged to honor all such requests.

The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize DOCTOR or agents thereof to make credit investigations, including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the DOCTOR receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

Not all services and/or fees are covered or paid for by the Responsible Parties' health PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.

All proceeds from the PLAN are assigned to DOCTOR where applicable. Payments to DOCTOR may not be withheld, delayed or excused for any reason; including the outcome of medical treatment, liens, lawsuit, any coverage determination by the PLAN or their processing of claims, the financial insolvency of the PLAN and/or their contracted intermediaries & medical groups. Responsible Parties are strongly advised to monitor and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to DOCTOR.

If any account balance is not paid in full within 60 days, the entire account balance will be subject to a MONTHLY FINANCE CHARGE of 1.5% and a MONTHLY COST OF REBILLING/ACCOUNT MAINTENANCE CHARGE of $8.00. These rates and charges are subject to change upon written notice 30 days in advance of changes.

If any account balance should remain unpaid for 60 or more days the account may be referred to a collection agency or attorney for collection. In a legal action between the parties to this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs. We require a 24 hour advanced notice for appointment cancellations. If you fail to show for an appointment with no prior notification your account will be assessed a fee. We reserve the right to refuse scheduling an appointment if you have failed to show for previously scheduled appointments. Pre-payment of services may be required to reschedule for those with a history of no showing appointments.

The Responsible Parties acknowledge receipt of DOCTOR's Office Policy that includes the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with DOCTOR's Office Policy contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. Outside referrals, orders and or hospital admissions are the responsibility of the insured to obtain authorization if required for treatment or admission. The DOCTOR is not responsible or cannot be held liable should the patient's PLAN not cover outside referrals, orders or hospital admissions. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto.

Agreed to and accepted by the Responsible Parties:

Signed by First Responsible Party **Print Name** **Date**
(If Patient is under 18 years old, Parent, or Guardian; Spouse or other Guarantor)

Signed by Second Responsible Party **Print Name** **Date**
(If patient is under 18 years old, Second Parent, or Guardian; Spouse or other Guarantor)