PRIMARY CARE OF CEDAR HILL
Authorization and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third part carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid claims). I acknowledge that I financially responsible for services rendered, and failure to pay and outstanding balance(s) may result in collection procedures being taken. Your past due balance will be forwarded to a national collection agency, at which time, a 10% collection fee will be added to your original balance amount. This additional fee will become part of your account balance and your responsibility to be paid in full. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to appointment, I will be considered a “no show” and may be subject to a “no show” charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial Policy, Authorization and Consent for Treatment, and hereby agree to them:

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Patient or Parent/Guardian if Minor Date