Scott Tushla, MD

Authorization for Claims Payment and Reviews

I. **Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance professional corporations for service rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Scott Tushla, MD system (or its affiliate), the independent contractor physicians and/or corporations for service rendered to me during the applicable periods of medical care.

II. **Unauthorized, Non-Covered, or Out of Plan Service** – I understand if my Insurance Plan(s) does not consider this visit or any service rendered during this visit or has not authorized this service, they will not pay for this visit or service rendered during this outpatient visit. I agree to be fully responsible for payment to Scott Tushla, MD Family Practice for this outpatient visit or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/ Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

III. **For Medicare Recipients Only** – I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the facility and/or independent contractors for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related service. In the case of Medicare art B benefits, I request payment either to myself or the party who accepts assignment.

IV. **Residents, Interns or Medical Students** – I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other healthcare professional, in my care as part of the Scott Tushla, MD Family Practice.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accepted the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Scott Tushla, MD Family Practice. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Scott Tushla, MD Family Practice, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____