## INSURANCE AUTHORIZATION & PAYMENT POLICY

- As a courtesy to our patients we are happy to bill your insurance carrier upon receiving all current and complete information. It is the patient's responsibility to provide this information at the time of service. If we are unable to receive or verify this information, we will not be able to submit a claim for you and will provide you with an itemized receipt to submit for reimbursement from your insurance carrier.
- All co-pays for office visits and applicable services must be paid at the time of service.
- All Blue Cross/Shield Master Medical patients must pay for office visits at the time of service. We will submit claims to BCBS for reimbursement directly to you.
- Payments can be made by cash, personal check, money order, MasterCard or Visa.
- There will be a $25.00 charge for all returned checks.
- Outstanding balances exceeding 90 days may result in being discharged from the practice.

I request payment of approved benefits be made directly to Bay Area Family Physicians, P.C. for all services provided to me by them. I authorize the release of my medical information to my insurance company or its agents to assist in determining benefits payable. I understand that my insurance company may not pay for these services and I will become responsible for any balance on my account.

Signature_____Date_____

Insurance Company: _____

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Bay Area Family Physicians, P.C. to release my private medical information to the following person(s), if they are involved in the status of my healthcare or payment of health care, provided that the information is relevant to the person's involvement with the patient:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Health information may include, but not limited to, test results, medication changes and appointment scheduling. If you identify certain specific results or information that you do not want other people to have access to, then we will abide by your request. In the event of emergencies, I understand that my medical information might be shared on a need to know basis, at the discretion of my physician.

_____Date_____

Signature