DRS. BORDERS, HOOD & ASSOCIATES

Patient Name (Please Print) _____ **Date of Birth** _____

AUTHORIZATIONS

Permission is hereby granted to Drs. Borders, Hood & Associates to release information to my insurance company, employer, attorney, workers compensation carrier, physician or facility referred to for further treatment or testing, and/or my referring/family physician.

Signed: _____ **Date:** _____

Permission is hereby granted to any facility with which I have previously been treated to release medical records/X-ray(s) to Drs. Borders, Hood & Associates.

Signed: _____ **Date:** _____

MEDICARE PATIENTS ONLY: I authorize payment of medical benefits to Drs. Borders, Hood & Associates (if requested) for services rendered and I authorize the release of medical information to HCFA and its agents.

Signed: _____ **Date:** _____

HIPAA AUTHORIZATIONS

Please list below the individuals with whom we may discuss your medical care (please print).

	Name	**Relationship**	**Phone Number**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

I understand that I have the right to revoke this authorization at any time by providing Drs. Borders, Hood & Associates with written notice. I also understand that any revocation shall be effective the date it is included in the medical record and will not be retroactive.

Patient Signature _____ **Date** _____

PLEASE COMPLETE OTHER SIDE

DRS. BORDERS, HOOD & ASSOCIATES

FINANCIAL and PRIVACY POLICY

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policy as an essential element of your care and treatment. To assist you, we are providing herein a written statement of our policy. If you have any questions of concerns, please feel free to discuss them with our Patient Accounts Staff.

INSURANCE FILINGS, YOUR FINANCIAL RESPONSIBILITIES, and OTHER

- I have been offered and/or received a copy of Drs. Borders, Hood & Associates Notice of Privacy Practices.
- For services rendered to minors or those having legal guardians, the legal guardian is responsible for payment unless court documents declaring otherwise are presented at time of service.
- For patients without insurance coverage, payment will be due for all services on the day they are rendered. We accept cash, check, or credit cards **(Mastercard, Visa, and American Express)**.
- We have made prior agreements with many health plans. We will file all **health** claims (*excluding auto, worker's comp, and third party injury claims which we will provide you with an itemized statement at check-out*) providing that you give us your current insurance information prior to receiving services. If you have coverage with an insurance plan that we do not have a prior agreement, full payment is due at the time services are rendered.
- In the event that your insurance card does not reflect your co-pay amount and you do not know the amount, we will collect a $25 deposit.
- In the event an insurance determines a service to be "not covered," fails to acknowledge your coverage, or pay an appropriately submitted claim within 30 days from date of service, the responsible party is liable for any balance due and should be rendered upon receipt of a statement from our office.
- If your insurance requires you to obtain a referral prior to receiving a service from our physicians and you have not done so, you will be expected to pay for services in full at the time services are provided.
- Delinquent balances over 90 days old may be referred to an outside collection agency and an additional 35% processing fee will be placed on the account.
- In the event hospital services are provided, you are responsible for providing us with your current insurance information within one week of your discharge from the hospital.

MEDICARE NEW PATIENT

There is a possibility that Medicare will not cover a portion of your "initial exam." In this instance, you may be responsible for any amount Medicare does not cover.

SERVICE FEES

Due to increased costs, a service fee of $25.00 will be appended to your account for the following: returned checks, copays not paid on day of appointment, no-show's without prior notice, and balances not paid within 30 days of your notice.

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I have read and understand the above policy and statements and agree to be bound by the terms. I also understand and agree that such terms may be amended at any time by Drs. Borders, Hood & Associates.

_____ _____

Signature of Patient or Responsible Party **Patient Name (Please print)**

_____ _____

Date **Patient Date of Birth**

PLEASE COMPLETE OTHER SIDE