EASTSIDE INTERNAL MEDICINE, PC

Payment Responsibility and Insurance Release of Information

Patient Name: _____ DOB: _____

- I request payment of approved benefits be made directly to Eastside Internal Medicine, P.C. (EIM) 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 authorize EIM to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, or any other insurance carrier any information needed to process any medical claim I may incur.

- I understand that it is my responsibility to understand my benefits. My Insurance is a contract between myself and my insurance company. I will contact my insurance company regarding any questions about my benefits.

- I will inform EIM immediately when there are any changes to my insurance coverage.

- I understand that I am responsible for my deductibles, co-payments, co-insurance payments, percentages, deductibles, non-covered services, or services rendered without proper referral authorization, or denied services.

- EIM accepts cash, personal checks, money orders, Visa or MasterCard. All co-pays must be paid at the time of service. There will be a $15.00 administrative fee when co-pays are not paid at time of service. Outstanding balances are due within 30 days.

- I understand that I may be charged for any appointments that I miss without notifying the office at least 24 hours in advance ($40 for office visits, $75 for annual physical exams) and for any returned checks ($25 insufficient funds fee). Please note that our phone system accepts messages after hours and on weekends in the event you need to cancel or reschedule appointments.

- I understand that any appointment where I arrive 30 minutes late will have to be rescheduled and will be considered a missed appointment. Any applicable charges will be applied.

- This authorization for release of information is effective so long as necessary. This authorization may be revoked at any earlier time, in writing, except to the extent that our office has taken an action in reliance on the use or disclosure indicated in the authorization.

***A copy of our complete financial policy is available upon request.*

Patient Signature: _____ ***Date:*** _____