Marshall/Albion Medical Associates P.C.

A Partnership for Life

Dear Patient:

We welcome you as a new patient to our office and are pleased to extend to you every possible courtesy. To avoid billing and insurance problems, we would like to review with you the office policies of Albion/Marshall Medical Associates. Payment/cop-pays are expected as services are rendered. If for some reason this is not possible, please arrange to discuss this matter with the practice manager.

If you have health insurance please read your policy, so you know your coverage. Our office will be happy to submit your claim to your health insurance company for whatever portion of your rendered services they will cover, although it is important that you realize **a portion, or all of the total fee may be your responsibility.** In some cases, insurance policies cover only a small portion of the total expenses. If you change insurance companies, please NOTIFY OUR OFFICE.

Health insurance is designed to help you meet the cost of medical services. In most cases it does not pay the total fees. Your insurance contract defines your coverage. The office's insurance specialists will be happy to discuss any phase of our office policy or specific insurance plan. We encourage an open discussion of charges and payment procedures.

Patient Authorization:In order to submit a claim to your insurance carrier for services rendered we must have the following authorization file.

MEDICARE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare of payment.

Signature:_____Date:_____

I authorize Marshall Medical Associates to initiate a complaint to the insurance commissioner on my behalf for any reason.

Signature:_____ Date:_____

OTHER HEALTH INSURANCES

I authorize Marshall/Albion Medical Associates to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the Practice and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Marshall/Albion Medical Associates for covered services. I also authorize Marshall/Albion Medical to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

Signature:_____Date:_____

Please see other side