PRIMARY CARE MEDICAL CENTER OF GULFPORT, PLLC
INSURANCE ASSIGNMENT OF BENEFITS - BILLING AUTHORIZATION
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

Primary Care Medical Center of Gulfport, PLLC is herein referred to as PCMC.

I hereby instruct and direct the carrier of my medical insurance coverage for myself and/or my dependents to pay by check made out and mailed to Primary Care Medical Center of Gulfport, PLLC **OR** If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to 15444 Suite B Dedeaux Road, Gulfport, MS 39503. For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

1. I understand and acknowledge that I am financially responsible to PCMC for all charges for PCMC, services provided to me and/or my dependents including co-pays, deductibles or charges not covered by any insurer or third party payers.
2. I acknowledge that PCMC can charge a service fee of $40.00 to my account in the event that I remit payment for services with a check that is returned due to insufficient funds.
3. I understand PCMC reserves the right to collect all charges related to patient accounts placed into collections including but not limited to collection agency fees, attorney fees and court costs.
4. I agree to pay the charges for care provided to me or my dependents within 60 days of the date of the first monthly bill.
5. I understand that my co-pays, deductible and co-insurance are due at the time of service, unless other arrangements are made with PCMC.
6. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
7. I authorize the treating doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
8. I understand that I cannot retract this authorization for the release of medical records until my account balance is fully satisfied.
9. All patients without insurance coverage are required to make payment at the time of service.
10. A photocopy of this assignment shall be considered as effective and valid as the original.

No Show Policy: Patients who do not show up for a scheduled office or lab visit, or who do not cancel the appointment the day before, will be charged a $25.00 fee.

I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms.

HIPAA NOTICE ACKNOWLEDGEMENT FORM
A NOTICE OF THE HIPPA PRIVACY POLICY IS AVAILABLE IN THE LOBBY. PLEASE TAKE ONE.
OR PRINT A COPY FROM OUR WEB SITE: www.primarycaregpt.com

PRIMARY CARE MEDICAL CENTER OF GULFPORT, PLLC reserves the right to modify the privacy practices. I am aware of the HIPAA NOTICE OF PRIVACY PRACTICES FOR PRIMARY CARE MEDICAL CENTER OF GULFPORT, PLLC, and copies of the notice are available for me to take if I choose to have one.

These terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of PCMC. I acknowledge that I have read and understand all the information outlined in this document that applies to my visit and that my signature below signifies my agreement to comply with the terms. I understand that I can request a copy of this agreement.

(PRINT PATIENT NAME) _____ (SIGNATURE OF PATIENT) _____

(SIGNATURE OF PATIENT REPRESENTATIVE) _____ (RELATIONSHIP TO PATIENT) _____

(DATE) _____