

INSTITUTE OF DIABETES & ENDOCRINOLOGY, PC

221 STEWART AVENUE, SUITE 101, MEDFORD OREGON, 97501

Phone: 1-541-776-2003

Fax: 1-541-776-9833

CONDITIONS OF TREATMENT

Patient Name _____

Date of Birth _____

Today's Date _____

1. **Insurance Verification and/or Pre-Authorization** - Many insurance companies require pre-authorization or a second opinion for some medical procedures. The Institute of Diabetes and Endocrinology, PC will assist the patient in obtaining the necessary pre-authorizations or second opinions when needed. It is ultimately the patient's responsibility to determine the procedures in which these things are needed. Failure to obtain necessary pre-authorization or second opinions may result in a reduction or rejection of benefits by the insurance company.

2. **Assignment of Insurance Benefits** - I hereby authorize my insurance company to pay the Institute of Diabetes & Endocrinology, PC directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective as the original.

3. **Confidentiality** - Confidential information expressly identifies the medical nature of the service rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physician examination, diagnosis, treatment rendered, laboratory and radiology results, progress notes, and miscellaneous medical reports.

4. **Medicare authorization: Patient's certification authorization to release information and payment request** - I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named above to release such information to the Social Security Administration or its intermediaries or carriers, effective from (today's date) _____ forward.

5. **Authorization for disclosure of Information for Purpose of Service Reimbursement** - I hereby authorize the Institute of Diabetes & Endocrinology, PC to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release the Institute of Diabetes & Endocrinology, PC from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing, except to the extent that the Institute of Diabetes & Endocrinology, PC has already taken action on my claim.

6. **Financial Agreement** - I understand that in consideration of the services rendered, I am obligated to pay the Institute of Diabetes & Endocrinology, PC in accordance with its regular rates, terms, or contractual agreements. I understand that I am responsible for any service "not covered" by insurance and that the obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collection, I agree to pay all collection expenses.

7. The **Institute of Diabetes & Endocrinology, PC** reserves the right to amend this form at any time. I, as a patient, have a right to the amended form.

8. **I have read and understand this financial agreement. I have had an opportunity to ask questions and, at my request, received a copy of my signed form. I accept the responsibility of its terms.**

Patient Signature

Date