MWMC Manhattan Wellness MEDICAL CARE マンハッタン・ウェルネス・メディカル

FINANCIAL AGREEMENTS

Patient Name Last _____ First _____ MI ____

1. Release of Information
I hereby authorize and direct Manhattan Wellness Medical Care, PLLC and/or any provider or organization rendering medical services at the offices located below to release to governmental agencies, insurance carriers, or others who are, or may be, financially responsible for my medical care, all information needed to substantiate payment for such medical care, and to permit representatives thereof to examine and make copies of all records relating to my care and treatment.

Date _____ Signature _____
Patient or Responsible Person

2. Assignment of Benefits
I hereby assign to Manhattan Wellness Medical Care, PLLC and/or any provider or organization rendering medical services at the offices located below any and all benefits, including benefit of payment, to which I may be entitled from any governmental agency, insurance carrier, or others who are financially responsible for the medical care rendered to me or my dependent at said offices.

Date _____ Signature _____
Patient or Responsible Person

3. Medicare Insurance
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 regarding my treatment, to release to the Social Security Administration and/or the Health Care Financing Administration or its intermediaries or carriers, any information needed for this related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or provider rendering the services or authorize such physician or provider to submit a claim to Medicare in my behalf.

Date _____ Signature _____
Patient or Responsible Person

4. Blue Cross and Blue Shield, United Healthcare and Oxford Subscribers
I have been advised that my provider(s) is/are **not** participating with the above insurances and therefore I will be fully responsible for the cost of services. A courtesy claim will be sent to my insurance carrier on my behalf. If my insurance carrier sends payment to me for the service, I will immediately remit the payment and explanation of benefits to Manhattan Wellness Medical Care, PLLC.

Date _____ Signature _____
Patient or Responsible Person

5. Financial Agreement and Guarantee
For services rendered or to be rendered, the undersigned agrees to pay to Manhattan Wellness Medical Care, PLLC and/or any provider or organization rendering medical services the full amount of bills not paid by my insurance plan. I understand that all such bills are due and payable at the time services are provided or upon receipt of a statement from our billing office. Payment may be demanded at any time from either of the undersigned and failure to demand payment of the patient shall not be a prerequisite to the guarantor's immediate responsibility for payment.

I have read this agreement and fully understand it's nature and significance. I have retained a copy of this agreement and a copy of Manhattan Wellness Medical Care, PLLC's Payment Policy.

Date _____ Signature _____
Patient or Responsible Party
(Parent if a Minor)