Florida Institute for Reproductive Medicine
Baptist Medical Center Pavilion
836 Prudential Dr., Suite 902
Jacksonville, FL 32207
(904) 399-5620

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

1) I authorize this office to release or receive any information necessary to expedite insurance claims
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier I agree to endorse any payment I have received over to my physician for which these fees are payable.

FINANCIAL POLICY

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility. Accordingly, we have prepared this material to acquaint you with our policy.

1) I understand that it is my responsibility to obtain referrals from my primary physician or health plan prior to my appointment.
2) I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance.
3) I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee.
4) I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 90 days, it is my responsibility to pay my doctor's bill directly.
5) I also understand my co-payment is due at the time of service for each visit.
6) I understand that F.I.R.M. obtains benefit coverage as a courtesy *only* and is in no means liable for any misinformed information given by the insurance company. Furthermore, I understand that I am responsible for verifying insurance coverage myself.

I further understand and agree, that if I fail to make monthly payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee. *A Photostatic copy of these authorizations and agreements shall be as valid as the original.*

Signature _____

Date _____

Witness _____