

Authorization to Release Information, Assignment of Insurance Benefits Agreement/Contract

I hereby authorize the release of any medical information requested by the insurance companies to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at NCC.

I understand and agree that health insurance policies are an arrangement between an INSURANCE CARRIER AND ME. I understand and agree that it is my responsibility to pay any deductible amount, co-insurance, co-pay or any other balance resulting from services denied by my insurance plan.

I understand it is my responsibility to provide a valid referral for North Cascade Cardiology, PLLC.

If I do not have health insurance, I acknowledge full responsibility for the payment for services rendered to me and agree to pay for them in full at the time of service, unless other arrangements have been made in advance with the office.

I understand that a rebilling fee-finance charge will be applied to any overdue balances. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

MEDICARE: I understand my provider agrees to accept the Medicare allowed charges as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

I understand that this agreement applies to all services performed at North Cascade Cardiology, PLLC and is in effect until specifically revoked in writing.

Signature, Responsible Party

Date

Please Print Patients Full Name