



SPECIFIC AND IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF RIGHTS AND BENEFITS

I hereby authorize, Genesis Family Health Center, PLC the right to release any information they deem appropriate concerning my health condition to insurance companies, attorneys or adjusters in order to process claims for reimbursement of charges incurred by me.

I hereby authorize and assign direct payment to Genesis Family Health Center, PLC from my attorney. This sum being the proceeds of any settlement of my case used to cover services rendered. I do not agree to the withholding of attorney fees from the amount due to me.

I hereby authorize and assign direct payment to Genesis Family Health Center, PLC from my insurance company or any insurance company that may be involved. The sum being reimbursement for charges or services rendered to me by Genesis Family Health Center, PLC.

I give assignment and lien against any claims against a third party for their negligence which may have caused the patient's injury up to the amount of the bill for treatment.

In the event that an insurance company obligated by contractual agreement to make payment to me or to Genesis Family Health Center, PLC for the charges incurred at the clinic, refuses to make payment upon demand by clinic, I hereby assign and transfer to Genesis Family Health Center, PLC the cause of action that exists in my favor against any such company (the names of which is believed to correctly set forth under pertinent date below) and authorize said clinic to compromise, settle or otherwise be resolve said claim as seen fit by clinic.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

I understand that there is a \$30.00 charge for each check returned as 'non-sufficient funds' in addition to the original charge.

I agree that, by execution of this agreement, if collection proceedings shall become necessary to collect the balance of my account at any time, I will be responsible for the costs of collection, including, but not limited to attorney fees and the interest rate of 18.9% per annum.

I understand that an annual administrative fee of \$35.00 per adult (age 18 or older) and \$20.00 per child (ages of 4 to 17) will be assessed to cover those administrative services including, but not limited to medical record requests, forms completion, applications, licensing requests, prescription refills that are requested between appointments, etc. This fee will not be billed to the insurance carrier; and will be collected at the time of the first appointment and annually thereafter.

As a service to all patients, our office will bill insurance carrier(s) for services rendered and covered benefits. If the insurance carrier does not pay within 90 days of being billed, the balance remaining is the responsibility of the patient to pay in full, regardless of the insurance coverage, unless prior arrangements have been made and approved. It is each patient's responsibility to work with their insurance carrier to receive reimbursements which may be due after this balance has been paid. Please check with the front desk for the most current information on your account balance.

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(continued)

I understand that I am responsible for keeping scheduled appointments. Should I not keep an appointment as originally scheduled, I will notify the office no later than 5:00 pm of the business day prior to the appointment to either cancel or reschedule the appointment. If I do not show for a scheduled appointment without prior notification as stated, I understand that I will be charged (not my insurance carrier) a minimum of \$50.00 for failure to show for an appointment without following these guidelines. Emergencies will be considered on a case by case basis. Furthermore, I understand that if I fail to show for a total of three (3) scheduled appointments without notification within a twelve (12) month period, that I will be given a certified, written notification of dismissal from the practice and 30 calendar days from the date of the letter to locate another primary care physician for my medical care. Parents and legal guardians will be held responsible for missed appointments of minor children.

I have the right to refuse services. By signing this form, however, I give authorization to receive services and will allow the use of digital photographic equipment (if necessary) to diagnose and formulate my treatment plan.

Genesis Family Health Center, PLC supports continuing medical education and training. At times, our office may host visiting medical residents, nursing students, physician assistants, etc. who are in training for the medical profession. I understand that I may be asked, on occasion, to allow one or more of these individuals to participate in my health care. I further understand that these individuals will be under the direct supervision of the office physician and that s/he will ultimately determine the course of my treatment.

I have read and agree to the terms as outlined in this document.

Patient Signature

Date

BLUE CROSS & BLUE SHIELD OF MICHIGAN: I understand the Blue Cross and Blue Shield of Michigan benefit payment for the services provided will be sent directly to me by Blue Cross and Blue Shield of Michigan, and I agree to be responsible for any amount which exceeds the Blue Cross and Blue Shield of Michigan benefit payment that the provider charges for such services.

Patient Signature

Date

MEDICARE: I request payment of authorized Medicare benefits be made either to me or on my behalf to Genesis Family Health Center, PLC for services furnished me by any employee of Genesis Family Health Center, PLC. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Date