Fall General Surgery, LLC

Authorization to Pay & Release Medical Records

Our office will bill your insurance. It is your responsibility to understand your insurance plan and coverage details. You are responsible for the deductible, co-insurance, co-payments at the time of visit, and any costs not covered by your insurance company. If you do not have insurance we require payment at the time of your visit. Our staff is available is you have any questions or concerns. Fall General Surgery, LLC reserves the right to withhold overpayment refunds less than or equal to $5.00.

I authorize payment of medical benefits be made directly to Fall General Surgery, LLC for services rendered. I authorize release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize use of information from this for to bill my insurance companies.

_____ _____

Signature of patient (or parent/guardian if patient is a minor) **Date**

Access to Medical/Billing Information

Please **List** the Name(s) of any person; for example: your care giver, spouse, brothers, sisters, moms, dads, sons, daughters, etc. you would like to have *Access* to your **Medical/Billing Information**; for example: verifying appointments, picking up prescriptions, speaking to our billing department about your bill, speaking with the doctor about your care, etc., *on a regular basis*. *If you prefer not to list anyone below, please state No One or None.*

List or No One: _____

By signing below, I give permission for the above named people to have access to my medical and/or billing information on a regular basis and it allows Fall General Surgery, LLC and its staff members to relate information regarding my care to these named people. I understand that this is effective for one (1) year from the date of my signature and does not grant access to my medical record.

_____ _____

Signature of Patient (or parent/guardian is patient is a minor) **Date**

Patient Name if the Patient is a Minor or Patient Representative signed:_____