PATT INTERNAL MEDICINE

Signature on File, Assignment of Benefits, Financial Agreement

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Beneficiary Name (print) Medicare Number

I understand and agree to the following:

1. Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Patt Internal Medicine for services furnished me by Dr Patt. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Patt Internal Medicine accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier regardless of any other oral or written estimate or assumption by any member of the staff of Patt Internal Medicine.

2. Medigap: I understand that if a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Patt Internal Medicine. if possible or otherwise to me.

3. Release of Information: Patt Internal Medicine. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to him for reimbursement for services rendered, and (2) any health care provider for continued patient care. Dr. Patt may also disclose on an anonymous basis and information concerning my case which is necessary or appropriate for the advancement of medical science, medical research,

medical education for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

4. Non-Covered Services: I understand that Dr. Patt's contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Patt Internal Medicine to obtain necessary health care service plan authorizations. In some cases, it may be necessary for me to cooperate with the execution of a specific **Medicare Advance Beneficiary Notice** (ABN) for certain non-covered services.

5. Financial Agreement: I agree that in return for services provided to the patient by Patt Internal Medicine, I will pay to my account at the time service is rendered or will make financial arrangements satisfactory to Patt Internal Medicine for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Patt Internal Medicine.

If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Patt Internal Medicine. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

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Beneficiary Signature or Authorized Party Date

Special Information:

1. Medicare does not cover any services which are deemed medically unnecessary, even if your doctor finds a medical diagnosis warranting such care.
2. Medicare may deny benefits if they feel you are receiving examinations too frequently, or are receiving exams by more than one doctor for the same illness.
3. Your signature on this form will serve as your "signature on file" and permission for release of information to Medicare or supplemental insurance.
4. Dr Patt may at any time terminate a contract with any insurer. Any insurer may terminate its relationship at any time with Dr Patt. In either case, these actions can occur without any requirement of advance written or oral notice notice to the patient.