PERMISSION TO FILE CLAIMS WITH YOUR HEALTH INSURANCE

PLEASE READ THOROUGHLY AND SIGN ONE OF THE OPTIONS BELOW.

Should I agree to use my Health Insurance, I understand the following:

1. Health Insurance will be billed *FedCare*'s usual and customary fees.

2. Any medications dispensed through our dispensary are the patient's responsibility and will not be billed to health insurance. If you wish instead to receive a written prescription and fill it at an outside pharmacy, you may request this when you see the provider.

3. *FedCare*'s providers are not enrolled as participating providers through any commercial health insurance carrier. The filing of claims does not guarantee either full or partial payment from your insurance.

4. Since *FedCare* is an out of network provider, if your health insurance company issues a check directly to you (the patient) for payment of medical services rendered at our office, you (the patient) will be responsible for signing it over to *FedCare*.

5. Because *FedCare* is an out of network provider, you (the patient) will be responsible for any amounts which are unpaid by your health insurance carrier.

Health Insurance File/Waiver Agreement

OPTION A. (File Health Insurance)
I have read the above statements and **AGREE** to have *FedCare* file my Health Insurance. I hereby authorize payments from my insurance company to the physician for medical services provided. I further understand that I am responsible for payment of any services not covered by my health insurance which includes, but is not limited to, co-pays, co-insurance, amounts applied to my deductible, and/or services unpaid by insurance.

_____ _____
Signature of Patient Date

OPTION B. (Do not file Health Insurance)
I have read the above statements and **DECLINE** to have *FedCare* file any of my medical services to my Health Insurance. I further understand that, I am considered as contracting outside of my insurance network for services provided by *FedCare* by declining to have *FedCare* file my Insurance for any service provided. I understand that I will be responsible for payment for any services rendered which are unpaid by insurance.

_____ _____
Signature of Patient Date

OPTION C.(Have no insurance)
I have read the above statements and I **DO NOT** have any Health Insurance. I understand that I will be responsible for payment for any services rendered which are unpaid by insurance.

_____ _____
Signature of Patient Date

By signing this acknowledgement, I am indicating that I have read and understand the above information and authorize the release of any medical or insurance information to the insurance company which is necessary to process claims for services rendered by this facility. I hereby authorize payments from my insurance company to the physician for the medical services provided. I understand that I am fully responsible for all charges regardless of my insurance benefits. I understand and have read the agreement and options above and have chosen one. I have also been given the opportunity to ask questions and they have been addressed.

_____ _____
Signature of Patient **Signature of Staff Member**