

Teri Perryman, M.D., P.A.

513 Granada Place
Kerrville, Texas 78028
(830) 896 - 2758

ASSIGNMENT OF BENEFITS FORM

_____ **Financial Responsibility**

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage; this includes Co-pays, Co-Insurance, Deductibles, and/or non-covered services.

_____ **Assignment of Benefits**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan to issue payment check(s) directly to Teri Perryman, M.D., P.A. or Teri Perryman, M.D. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. . A photocopy of this assignment is to be considered as valid as the original.

_____ **Authorization to Release Information**

I hereby authorize Teri Perryman, M.D., P.A. or Teri Perryman, M.D. to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing. . A photocopy of this Authorization is to be considered as valid as the original.

REQUEST FOR SERVICES and FINANCIAL RESPONSIBILITY

I have requested medical services from Teri Perryman, M.D., P.A. or Teri Perryman, M.D. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement

NO INSURANCE _____ (initial)

I do not currently have any form of third party reimbursement insurance, either privately, through an employer or under a State or Federal program, including Medicare and Medicaid.

I further understand that Teri Perryman, M.D. P.A., does not accept retroactive assignment of benefits for services previously rendered. Upon becoming eligible or covered under any of the previously stated third party reimbursement programs, Teri Perryman, M.D. P.A. will only recognize such coverage from the point in time that I notify Teri Perryman, M.D., P.A. and forward, and will not bill or file claims for such programs for prior services rendered.

Should my account be turned over to an outside collection agency, I will be responsible for any and all additional fees, charges or expenses incurred by Teri Perryman, M.D. P.A. for collection of my outstanding account. I understand that Collection Agency Fees, State Sales Tax, Attorney Fees and/or Court cost may be added to my account prior to placement.

Patient/Responsible Party Signature

Date

Witness

Date