Patient Financial Agreement

I hereby authorize Clarksburg Medical Center Inc. to apply for benefits on my behalf for services rendered. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits be made payable to Clarksburg Medical Center Inc. on my behalf.

1. We participate with Medicare and Carefirst BlueCross BlueShield. By contract, covered charges will be paid directly to us. Any applicable co-insurance payments are/or deductibles are due at the time of service.
2. We participate with certain HMO/PPO programs; participants are responsible for their co-payments at the time of service.
3. Commercial insurance participants may be required to pay in full for charges at the time of service. As a courtesy, we will submit the insurance form on your behalf requesting that payment be made directly to you for reimbursement. If the commercial carrier agrees to pay the physician directly, you will only be required to pay you deductible (if not met), and any applicable co-insurance amount at the time of service.
4. A $35.00 fee will be charged to all patients for any returned checks.
5. I understand that I am financially responsible for any non-covered and/or denied charges incurred on my behalf and that it is my responsibility to know my insurance coverage guidelines.
6. A copy of this agreement may be used in place of the original.
7. I recognize that if I miss or do not show up for an appointment, I will be charged for a $25 fee.

Signature _____ **Date** _____

Acknowledgement of "Notice of Privacy Practices"

I have been presented with a copy of Clarksburg Medical Center of privacy practices, detailing how my information may be used and disclosed as permitted under federal and state law.

I understand the contents and I agree to the disclosures named in the notice.

Patient Initials _____