Patient's Name: _____ Date of Birth: _____ Sex: _____

Guarantor Information.

Name of person responsible for this account (Guarantor): _____

Date of Birth: _____ SS#: _____ Relationship to Patient: _____

READ CAREFULLY

The Guarantor is responsible for all charges regardless of insurance coverage.
All charges are due at the time of service.
If the patient has insurance coverage, we will submit claims, on behalf of the patient, for benefits for the services rendered. However, the guarantor is responsible for any applicable co-payments, coinsurance, deductibles and non-covered services.

Also if payment is denied or retracted because the guarantor did not fully disclose all existing medical insurance coverage, the guarantor becomes responsible.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, request that payment of all medical benefits, if any, be made to Joseph V. I. Osuagwu, MD, PC for services rendered to the above-named patient. I authorize the release of medical information about the above-named patient necessary to secure the payment of benefits. I understand that my signature makes me responsible for payment of any Co-payments, Coinsurance and Deductible, which are based upon the charge determination of the Health Insurance Carrier, and for Non-covered services. I further authorize the use of this signature on all insurance claims submitted on behalf of the above-named patient.

PRIVACY RESTRICTIONS.

I have received/reviewed a copy of my rights regarding my/my child's medical records and the practice responsibilities regarding protection and disclosure of this information (HIPAA Policy).

_____ _____

Signature of Patient/Guarantor Date