Susan R. Tucker, MD, FAPA

Patients with Insurance Coverage

Our office will automatically file all charges with your insurance once you have given us complete insurance information. If you do not want us to file your insurance, please let us know. If your insurance does not pay within forty (40) days please check with them in reference to payment. Please contact our billing service for any assistance you may need.

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Susan R. Tucker, MD for any services provided by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance is indicated in item 9 of the HCFA-1500 claim forms or electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases my physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

AUTHORIZATION AND CONSENT

I certify that the above information is true. I understand that all professional services are charged to the responsible party and that payment is expected at the time of service unless other arrangements have been made in advance. I also understand that regardless of insurance coverage the final responsibility for payment is mine. I authorize insurance payments to be paid, when appropriate, to Susan R. Tucker, MD. I also authorize release of medical information to my insurance carrier(s) when necessary to process a claim.

I have read and understand all of the above. The information listed on the front is correct to the best of my knowledge. I understand that I am responsible for all bills not paid by insurance. I further agree in the event of non-payment to bear the cost of collection and/or costs and reasonable legal fees should this be required. I understand that a fee of $75.00 will be applied to my account for any missed appointment not cancelled 24 hours prior to appointment time.

Co-pays that are not paid at the time of service are subject to a $5.00 administration fee.

_____ _____

Signature Date