

**DALE R MYERS MD**  
**SALLY WHITMAN PA-C**  
**Gynecology/Women's Health**

Please read the following

**Assignment of Insurance Benefits:** I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, Medicaid, Commercial insurance and other health benefits to: DALE R MYERS MD PC. In the event payment is made directly to me for services rendered by providers in this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize office of Dale R Myers MD PC to release all information necessary to secure the payment.

**Responsibility for copay / coinsurance / deductible amounts / pre-auths:** We bill insurance carriers for you, provided we are given the proper information. Since my agreement is with my insurance company, I understand this office may not routinely research why my insurance carrier has not paid. I agree to be fully responsible for paying my copay, co-insurance and deductible amounts at the time of service. I understand that it is my responsibility to contact my insurance carrier, prior to time of service, for any pre-authorizations. Even though my insurance may be filed, I understand that all bills are payable upon receipt and that I and/or my spouse/legal guardian, not the insurance company, are financially responsible for all charges whether or not paid by said insurance. If this account is assigned to an attorney or collection agency for collection suit, I shall pay all collection costs. This is also the case in small claims court and garnishment of wages. I understand any unpaid balance may accrue interest at the rate of 2% per month of unpaid balance. Failure to pay unpaid balance may result in termination from practice.

**SELF-PAY Patients:** I agree that in consideration of services to be rendered, I obligate myself to assume financial responsibility and agree to pay in full at time of service unless prior arrangements have been made. A 20% discount will be offered if payment in full made date of service. If this account is assigned to an attorney or collection agency for collection suit, I shall pay all collection costs. This is also the case in small claims court and garnishment of wages.

**Accepted forms of Payment:** We accept payment by cash, check and Credit Card (American Express, Discover, MasterCard & Visa). We also accept Care Credit, which cover health services including copays, co-insurance, deductibles and services not covered by insurance. Care Credit offers no or low interest payment plan options with no annual fees. It can be used at any participating Care Credit provider (including dental and veterinary). More information and application details can be found at [www.carecredit.com](http://www.carecredit.com)

**Acknowledgment of Notice of Privacy Practices:** I acknowledge I have read and understand the HIPAA Notice of Privacy Practices.

**Medical Records Release:** In event a referral is needed to another physician, I also hereby authorize release of medical information (limited to information related to referral).

**Missed Appointments:**  
In fairness to the provider and other patients, we require at least 24 hour notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice if a pattern of frequent last minute reschedules or no-shows occurs.

**Medication Download:** I give consent to Dale R Myers MD to download my medication history from my pharmacy into my electronic record.

\_\_\_\_\_  
Patient / Legal Guardian Signature

\_\_\_\_\_  
Date