



I have verified the insurance on this form and authorized my insurance benefits to be paid directly to RPSW. I also authorize RPSW, in accordance with the Federal Truth-in Lending Act, to release any information required for this claim.

**Office Financial Policy**

In our continued commitment to provide the highest quality of care available to all of our patients and to have those services comfortably affordable, we offer the following options:

**Private Pay (no insurance coverage)**

Payment is due at the time of treatment. We accept cash, check, Master Card, VISA, and Discover card. A \$30 fee will be charged for any check returned for insufficient funds or otherwise dishonored. The responsible party agrees to be personally and fully responsible for total payment of all procedures performed in this office.

**Insurance Coverage**

We will, as a courtesy, process your insurance claims in our office. This service is provided to help relieve you of this time consuming, and sometimes complicated task. The responsible party agrees to be personally and fully responsible for total payment of all procedures performed in this office.

I acknowledge I am financially responsible and agree I am responsible for: obtaining a referral authorization if I have a managed care program; providing this office with a current insurance card or cards and applicable co-payments at the time of service; rebilling fees on balances over 60 days at the rate of 1% per month with a minimum of \$2.00 per month; paying attorneys and collection fees if any delinquent balance is placed with an agency or attorney for collection or suit.

\_\_\_\_\_  
Signature or responsible party

\_\_\_\_\_  
Date

**A copy of this assignment is as valid as the original**

**Medicare Patients only-lifetime authorization**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Respiratory Physicians of Southwest Washington for any services furnished me. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Privacy Practices**

Your health information is a private matter, Respiratory Physicians of SW Washington has a "Notice of Privacy Practices Policy" that can tell you how this office handles your information. In general, that policy states, no other uses or disclosure of your health information will occur unless you tell us it is acceptable. You may cancel this consent any time by signing and dating a revocation form provided by us, or by writing, signing and dating a letter to this office. By my signature below I acknowledge that I have been given a current copy or the opportunity to read a current copy of the Privacy Policy for this office.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

Relationship to patient if signed by parent, legal guardian, etc. \_\_\_\_\_

"We are committed to providing excellence in a warm, caring, and professional environment for the mutual enrichment of all."