JAMES S. LINDER, M.D., P.C.

AUTHORIZATION TO PROVIDE TREATMENT, INSURANCE ASSIGNMENT, AND RELEASE

In consideration of the treatment(s) rendered and to be rendered I hereby authorize the medical provider James S. Linder, M.D., P.C., “Dr. Linder”, or any other medical providers authorized by it, to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interests (or the best interests of my dependent if I am signing as a parent/guardian).

Furthermore, I hereby assign, transfer and set over to James S. Linder, M.D., P.C. all of my rights, title and interest to medical reimbursement benefits provided by my insurance policy(ies) listed below and/or any other third-party payor responsible for paying for the services rendered by Dr. Linder or related medical providers. Should payment be made directly to me, I agree to immediately endorse such payment to Dr. Linder.

In those cases where payment is not collected at the time of service, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within ninety (90) days from the date billed unless there are other agreements in writing between me or my insurance company and James S. Linder, M.D., P.C. In the event of any dispute, I agree to pay Dr. Linder’s collection costs including, but not limited to, bad check charges, court costs, witness expenses and reasonable attorney’s fees. I further agree to pay an interest charge of 1% (one percent) per month on any balance remaining on this account beginning ninety (90) days from the date of service. If at any time a single visit is overpaid and amounts from other visits remain unpaid, I agree that Dr. Linder may apply the overpayment from one visit to the outstanding balance(s) from other visits. I understand that a refund will not be issued to me until all visits are paid in full and my account retains a credit balance.

I understand that it is my responsibility to know the requirements of my insurance policy and to comply with them. If Dr. Linder does not participate in my plan, I agree to be responsible for any costs not paid by my insurance company. Furthermore, if my insurance plan does not pay Dr. Linder, for any reason, I agree to be responsible for the costs of my treatment. If my plan requires pre-certification for certain services, I agree to inform Dr. Linder of these requirements and to be responsible for any bill if I fail to inform Dr. Linder of the pre-certification requirement.

I specifically give Dr. Linder the authority to release my medical records to any medical provider who needs access to them to provide appropriate medical care. Furthermore, Dr. Linder may release my medical records to those who perform Dr. Linder’s billing services and to any third-party payors who are responsible for my bill. I acknowledge receipt of Dr. Linder's privacy guidelines and have been given the opportunity to object to other listed reasons for release. These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to James S. Linder, M.D., P.C.

Patient/Responsible Party:____**Date:**______________________

Insurance Company (ies): ____ **and any insurance company (ies) that I may use in the future.**

If you are a Medicare patient with Medigap Insurance please read and sign below:

I request that payment of authorized Medigap benefits be made on my behalf to James S. Linder, MD, PC for any and all services furnished me by that supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits. This authorization is in effect until I choose to revoke it.

Patient/Responsible
Party: ____**Date:**________________________