JAIME ALTAMIRANO, M.D., P.A

Financial Policy

Assignment of Insurance Benefits
I authorize payment of Medicare, Medicaid or other insurance benefits, otherwise payable to me, for medical service rendered to me, directly to Jaime Altamirano, M.D., P.A.. These benefits are not limited to individual policies, group policies, work compensation, liability, PIP, or any other policy that may cover healthcare benefits

Where Medicare/Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to Jaime Altamirano, M.D., P.A. on my behalf.

Third-Party Benefit Collections
I authorized Jaime Altamirano, M.D., P.A. to act on my behalf as attorney in fact in the collection of benefits from any responsible third-party payer through whatever means may be deemed necessary, and the endorsement of benefit checks made payable to me and/or Jaime Altamirano, M.D., P.A..

Release of Information
I authorize Jaime Altamirano, M.D., P.A. to release copies of information in its possession, as acquired in the course of my examination and/or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance, Medicare and Medicaid payments

Use of Information
I authorize Jaime Altamirano, M.D., P.A. and authorized Agents to use the information acquired in the course of my examination and treatment to provide me with the information about Jaime Altamirano, M.D., P.A. and other matters that may be of interest to me regarding my health care.

Guarantee of Payment
I hear by understand that I am financially responsible for payment to Jaime Altamirano, M.D., P.A. for any charges not covered or allowable by my insurance company, and all deductibles, co-insurance, co-payments, and for any balances remaining after payment has been made by my insurance Company. This includes any denials of payment due to lack of medical necessity or pre-certification/authorization, lack of affiliation with an HMO or any constraint imposed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physician plus the cost of collection fees, and/or including reasonable attorney's fees if/when applicable.

I further acknowledge that I have read and reviewed the financial policies of Jaime Altamirano, M.D., P.A.

Patient Signature: _____ **Date:**_____