Montgomery SPORTS MEDICINE CENTER

PAYMENT RESPONSIBILITY (PLEASE READ CAREFULLY)

I understand that I have a personal and primary obligation to pay for all medical services when rendered and I agree to pay all bills promptly. I further understand that although Montgomery Sports Medicine Center may submit a bill to my insurance company for payments as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms of my policy. I am aware that insurance payment/reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding balance on my account, if such action is deemed necessary. In addition, I agree to pay interest **(at 1½ percent per month) on my outstanding account balance if this balance extends beyond thirty (30) days of receipt of my bill**. I agree to pay any additional fees and/or costs incurred in order to collect payments on account(s). I waive my rights under Maryland statute of limitation should reconciliation of my account extend beyond three (3) years from date of service.

Please be advised that some insurance carriers have limited or no benefits for durable medical equipment (slings, braces, prosthetics, etc.) Also custom-made braces are only partially covered by some insurance carriers. We will try our best to confirm your benefits at the time of service but be aware that you may have a co-insurance and or deductible that will remain your responsibility. Thank you for your cooperation.

_____**(Please initial)**

I request that direct payment of authorized medical benefits (including Medicare, Medigap, major medical benefits) be made to Eran Kessous, MD PC for any services furnished to me by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing administration and its agents, to my attorney, or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not paid by the insurance carrier.

Patient/Responsible Party Signature:_____**Date:** _____ .

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