Family Health and Sports Medicine

RELEASE OF INFORMATION
I, authorize my insurance company, organization, employer, hospital, physician, or pharmacist to release requested information with regard to attached claims and the expenses reported.

WAIVER OF LIABILITY
When dealing with Medicare or other insurance companies assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance companies as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. The patient may be notified of non-covered services by the physician.

I understand that I am responsible for meeting my deductible and forwarding my payments for services. Failure to do so will result in my owing the entire balance and any associated collection fees.

AUTHORIZATION OF PAYMENT FOR MEDICAL BENEFITS
Any and all benefits are hereby assigned to Family Health and Sports Medicine. I also authorize the release of medical records. I understand I am liable for charges not covered by the insurance. If it is necessary to enforce collection of any amount due, the patient agrees to pay all collection costs and charges including all court costs and reasonable attorney fees.

I authorize payment of benefits, as determined by the insurance company, directly to:

Family Health and Sports Medicine
65 Sockanosset Cross Road #301
Cranston, RI 02920

Signed:

_____ _____
Patient or Employee Date

_____ _____
Parent or Guardian if patient Under 18 years old

Relationship to Patient

Please feel free to contact our billing company A-Stat (401-723-5533) if you have any billing questions.