



**BlueBird
Care Physicians**

BlueBird Care Physicians LLC

Patient Financial Responsibility

Patient Name:

Date of Birth:

Release of Information: I hereby permit BlueBird Care Physicians LLC (BBCP) to release healthcare information for purposes of treatment, payment, or healthcare operations to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

Assignment of Benefits: I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to BBCP for all covered medical services and supplies provided to me during all courses of treatment and care provided by BBCP and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with BBCP, which will authorize and allow for direct payment to BBCP of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by BBCP.

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am always financially responsible to BBCP and/or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify BBCP of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by BBCP and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Fees: Failure to give 24-hour cancellation notice or failure to keep your scheduled appointment may result in a charge of \$25. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, a minimum of 24 hours' notice is required. Returned checks are subject to a \$25 fee.

I have read and acknowledge the information provided above as understood.

Signature of Patient or Legal Representative Witness:

Patient Name: