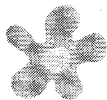

Mary A. Stanley, MD, FACS
Breast Surgery

# Patient Financial Agreement

## Authorization To Release Medical Information

I agree to allow Dr. Mary A. Stanley, MD, FACS, her affiliates and subsidiaries to release information regarding my medical treatment to any private or government insurance program that covers me, including Medicare and Medicaid, as necessary to verify benefits, authorize services, and process medical claims. In addition, release of medical records is authorized for my continuing care facility, any organization involved in the discharge planning process, any organization performing utilization review and any health care agency authorized by law.

## Authorization To Assign Insurance Benefits

I request that payment of authorized benefits under any private or government insurance program that covers me, including Medicare and Medicaid, be made on my behalf directly to Dr. Mary A. Stanley, MD. I understand by signing this form I am authorizing Dr. Mary A. Stanley, MD, FACS, to receive payments directly from any private or government insurance program that covers me for as long as I seek care with Dr. Mary A. Stanley, MD, FACS, or until I withdraw my consent in writing. I understand that I am liable to Dr. Mary A. Stanley, MD, FACS, for all related charges, whether or not covered by insurance.

## Statement Of Financial Responsibility

I acknowledge that I am legally responsible for all charges for the services provided to me by Dr. Mary A. Stanley, MD, FACS, to the extent those charges are not covered or paid by my insurance carrier/health plan or by another payment source such as Medicare or Medicaid. I understand that my insurance carrier/health plan may not approve or pay for the medical services provided by Dr. Mary A. Stanley, MD, FACS. I understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance except where my liability is limited by contract or State or Federal law. In the event of non-payment, I understand non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection including attorney's fees. Dr. Mary A. Stanley, MD, FACS, is authorized to access credit bureau files and reports now and in the future for collection purposes.

## Non-Covered And/Or Non-Medically Necessary Services

I acknowledge that I am legally responsible for all charges associated with the provision of non-covered and/or non-medically necessary services. I understand that Dr. Mary A. Stanley, MD, FACS, is not responsible for ensuring that I understand which services are not covered or are considered medically necessary by my insurance carrier/health plan, except were required by federal law. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care.

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| ______________________________ | ______________________ |
| Signature of Patient or Guardian | Date |
| | _________am____________pm |
| ______________________________ | |
| Relationship to Patient | Time |
| ______________________________ | ______________________ |
| Witness | Reason For Alternative Signature |