Dedicated Medical Care, LLC Policies

1. I understand that I am responsible for charges not covered by my insurance company. I agree, in the event of non-payment, to assume the costs of all interest and fees due to collection legal action. One statement will be sent to you as a courtesy. For each additional statement sent due to non-payment, a $10 billing fee will be added to your account. Payment for self-pay patients is due at the time of service.

2. I authorize my insurance carrier to release information regarding my insurance coverage to DRS Feldman and Galotto, LLC. I also authorize agents of any hospital, treatment facility or previous physicians to furnish DRS. Feldman and Galotto, LLC copies of any and all records of my medical history. I authorize the release of my medical records to any federal, state or accreditation agency. I agree to a review of my records for purpose of internal audits, research and quality assurance reviews within the office.

3. My right to payment for all procedures, tests, supplies and services including major medical benefits are hereby assigned to DRS. Feldman and Galotto, LLC. This assignment covers any and all benefits under Medicare, all government sponsored programs, private insurance companies, and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment for services. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to my representative, or me, I will endorse such payments to DRS. Feldman and Galotto, LLC.

4. I understand that when paying by check to DRS. Feldman and Galotto, LLC, I will be responsible for a $25 fee if a check is returned. This does not include any other fees applied by your bank.

5. I understand that I am responsible for any fees not covered by my insurance. In the event that my account becomes delinquent and is forwarded to an attorney or agency for collection, I am responsible for the fees including court costs.

6. I acknowledge receipt of the Notice of Privacy Policies provided by DRS. Feldman and Galotto, LLC. I am responsible for reviewing all information.

7. I authorize DRS. Feldman and Galotto, LLC to contact me for the following reasons:
    - Permission to call me at home, office, or mobile to confirm or reschedule an appointment, to provide me with test results, or to return my message(s).
    - Permission to leave appointment reminders or appointment cancellation notifications on an answering machine, voice mail, with a family member, secretary, or household employee.
    - Permission to leave "your test results were normal" on an answering machine.

I understand that missed appointments and appointments canceled without 24 hours notice are subject to a $25 fee.

Name of Patient and/or Guardian (please print):_____

Signature of Patient of Guardian: _____

Date: _____