Insurance Assignment and Authorization Form

Niceville Family Practice is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing the most current address, phone number, and insurance information at the time of service.

_____ I authorize payment directly to Niceville Family Practice of insurance benefits that may be otherwise payable to me by my insurance company (ies). I hereby transfer to Niceville Family Practice my right to payment from any insurance company (ies) that is/are responsible for my charges on this account.

Statement of Financial Responsibility

_____ I acknowledge that I am responsible for all charges for Niceville Family Practice services provided to me, whether insured in the past or future, including any amount not paid and or not covered by my insurance or other third party payors, excluding contractual insurance adjustments. I understand that Niceville Family Practice will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient by Niceville Family Practice within sixty (60) days of the date of the first monthly bill. Any account not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. Should collection action become necessary, I agree to pay reasonable attorney fees, expenses and court costs incurred by Niceville Family Practice.

_____ I have read and understand the terms stated above. The terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of Niceville Family Practice. I acknowledge receipt of a copy of this agreement.

Privacy Statement Agreement

_____ I acknowledge that information about me will be stored in an electronic medical record.

_____ I acknowledge that if I am a patient of Niceville Family Practice, Niceville Family Practice may access information about me for the purposes of treatment, payment and healthcare operations.

_____ I understand that I have the right to request that you restrict how information about me is used or disclosed for treatment, payment or healthcare operations. I understand that you are not required to agree with these restrictions, but if you do, you are bound by the restrictions.

_____ I acknowledge that I have been given the Niceville Family Practice Notice of Privacy practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Medicare Patients

_____ I authorize to release medical information about me to Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Niceville Family Practice.

I, the undersigned, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I give my consent to Niceville Family Practice to use and disclose information about me for the purposes described in this form. I understand that I can withdraw this consent, in writing, at any time except where you have already used or disclosed information in reliance on my prior consent.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

If patient is under 18, parent/guardian must sign below.

_____ _____ _____

Parent/Guardian Name Signature Date