Art of Medicine, P.A.
New Patient Authorizations

Financial Responsibility
This medical practice is dedicated to providing you the best possible healthcare services. It can do so only when you have a clear understanding of your financial responsibility. Even though you may have a current insurance policy, you are fully responsible for the payment of all services that are provided to you. Matters involving disputes with your health insurance company including those with respect to insurance verification, medical necessity, pre-certification, non-covered benefits, referrals, co-payments and deductibles are between you and your insurer. These issues do not release you from your financial responsibility to this practice.

Please be sure we have a current copy of your current health insurance card on file.
Due to the number of plans and their frequent changes, it is your responsibility to understand your plan benefits. Provision of service does not guarantee your insurance coverage.
Please note that all co-payments or deductibles are due at the time of your visit and are best paid in advance of being seen.

☐ I have read, understand and accept the above financial policy. Initials _____

Authorization of Assignment of Benefits
I hereby authorize Art of Medicine, P.A. to bill my health insurance directly for services and is authorized to receive direct payments to Art of Medicine, P.A. that otherwise would be payable to me. I permit a copy of this authorization to be used in place of the original.

☐ I have read and accept the above assignment of benefits. Initials _____

Authorization to Release or Receive Medical Information
I authorize Art of Medicine, P.A. to release or receive all medical information to all my insurance carriers or other third party payers as may be required or requested for the processing of claims or insurance payments or other insurance purposes.

☐ I have read and accept the above release of medical information. Initials _____

Authorization to Accept Arbitration *This specific authorization is optional.
I acknowledge and accept that all issues of medical liability regarding Art of Medicine, P.A. and Eduardo J. Balbona, M.D. are to be resolved by arbitration rather than litigation.

☐ I have read and accept the above authorization to accept arbitration. Initials _____

Acknowledgement:
I have read and understand the above financial policy and I authorize the assignment of benefits as well as the release and receipt of medical information as stated above.

_____ _____
Printed Name **SSN**

_____ _____
Patient or Patient Representative Signature **Today's Date**