South Shore Infectious Diseases
& Travel Medicine Consultants, P.C.
A.I.M.S- Antibiotic Infusion Medical Suite

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

   I understand that I am financially responsible for my health insurance deductible, coinsurance, non-covered service. Co-payments are due at the time of service.

   If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable" I will be responsible for the complete charge and agree to pay the cost of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

   I hereby agree to pay all charges due) or to become due) to South Shore Infectious Diseases & Travel Medicine, P.C. for care and treatment, including co-payments and deductibles as provided under my plan. I understand that I will be responsible for any charges if any of the following apply:

   - My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services and I have not obtained such authorization or referral or receive in excess of such authorization or referral, and/or
   - My health plan determines that the services I receive at South Shore Infectious Diseases are not medically necessary and/or not covered by my insurance plan and/or
   - My health plan coverage has lapsed or expired at the time I receive services and/or
   - I have chosen not to use my health plan coverage

   Please initial: _____

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

   I hereby authorize direct payment of my medical benefits to South Shore Infectious Diseases & Travel Medicine Consultants, P.C. on my behalf for any services furnished to me by the providers.

   Please initial: _____

3. AUTHORIZATION TO RELEASE RECORDS

   I hereby authorize South Shore Infectious Diseases & Travel Medicine Consultants, P.C. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of my treatment needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

   Please initial: _____

4. MEDICARE REQUEST FOR PAYMENT

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I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I South Shore Infectious Diseases & Travel Medicine Consultants, P.C. to release to

the Health Care Financing Administration or its carriers or intermediaries any information needed for this or a related Medicare claim. I hereby authorize payment, directly to South Shore Infectious Diseases & Travel Medicine Consultants, P.C., for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payment as may be due me from third party payers. I agree to execute such documents a may be necessary to apply for and obtain payment.

Please initial: _____

5. PAYMENTS
   - Returned checks are subject to a $25 fee and your account will be placed on a "cash only basis". We will accept payments only by cash or credit card until the balance is cleared.
   - Travel patients will be responsible to pay for all vaccines/services NOT covered by their insurance. Payment in full is expected within 30days of receiving a statement from our office. Failure to do so will put your account at risk of being sent into collections.

Please initial: _____

_____ _____

Patients name Patient signature

_____ _____

Patient representative Representative signature

_____

Date