Clovis E. Manley, MD, LLC
4943 Rosebud Lane
Newburgh, IN 47630

Patient's Name___________________________ **DOB** ________________ **Date** ________________

AUTHORIZATIONS, MEDICAL RECORDS RELEASE, ASSIGNMENT OF BENEFITS, FEES AND PRIVACY NOTICE

1. Treatment authorization. I expressly authorize this practice to provide me with reasonable and proper care by the standard of care in the community.

2. Medicare lifetime signature on file (applies to Medicare patients only). I request payment of authorized Medicare benefits be made to Clovis E. Manley, MD, LLC for any services furnished to me by this practice. I authorize any holder of medical information about me to release required information to the Center for Medicare and Medicaid Services (CMS) and its agents as needed to determine benefits and payment for benefits for services rendered. Our office accepts assignment on fees for our Medicare patients. We will submit your Medicare claims to CMS for you.

3. Assignment of benefits. I request payment of authorized medical insurance benefits be made on my behalf to Clovis E. Manley, MD, LLC. I understand the office will file my insurance claim as a courtesy to me. I am responsible for payment of co-pays, coinsurance, and deductibles for covered services. Services that are not covered by insurance are my responsibility and I agree to pay in full. I authorize the release of my medical information needed to process my insurance claims.

4. Insurance cards. I agree to inform the office of any changes in my insurance coverage in advance of obtaining any additional services. I will bring my insurance card to every visit.

4. Record copying fee. I understand I have a right to the information in my medical records, but the original records belong to my provider. I understand it is expensive and time consuming to copy medical records. I understand that a reasonable copying fee will be charged anytime I request a copy of my records or transfer my records to another provider. However, **I will not be charged** for: (1) copies of recent lab/imaging tests, (2) records sent to a specialist that the office refers me to, or (3) a copy of my most recent office visit.

5. Missed appointment fee. I understand I will be charged a **missed appointment fee** ("No Show" fee) of **$35.00** if I do not keep a scheduled appointment or if I fail to cancel at least 24 hours before the appointment. I also understand I will be charged a **missed procedure fee** of **$75.00** if I "no show" or fail to cancel a procedure or ultrasound at least 24 hours in advance.

6. Collection fees. I agree that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay any attorney fees or court costs incurred in the course of the collection of my fees. I agree to pay pre-judgment and/or post judgment interest on any overdue balance at the current legal rate.

7. Privacy policy. I received a copy of the Notice of Privacy Practices for Clovis E. Manley, MD, LLC.

Signature ___________________________________