Peter C. Brasch, M.D., LLC

1 Thurber Blvd.
Smithfield, RI 02917
ph (401) 349-5360 fx (401) 349-5270

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

Beneficiary Name: Medicare #:

☐ **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Peter C. Brasch, M.D. LLC for services furnished me by Doctor Brasch. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Peter C. Brasch, M.D. LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

☐ **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Peter C. Brasch, M.D. LLC, if possible or otherwise to me.

☐ **OTHER INSURANCE**: I authorize payment of my medical and surgical insurance benefits to Peter C. Brasch, M.D. LLC. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Peter C. Brasch, M.D. LLC. I authorize Peter C. Brasch, M.D. LLC to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

NON-COVERED SERVICES: I understand that Peter C. Brasch, M.D. LLC's contract with health care services plans relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. I agree to cooperate with Peter C. Brasch, M.D. LLC to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Peter C. Brasch, M.D. LLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Peter C. Brasch, M.D. LLC for payment. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I also understand that any insufficient fund returned checks may be prosecuted. Any benefits of any type under any policy of insurance are hereby assigned to Peter C. Brasch, M.D. LLC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Peter C. Brasch, M.D. LLC. **However, I understand that I am primarily responsible for the payment of my bill.**

6. HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices issued by Peter C. Brasch, M.D. LLC that was effective September 5, 2013

Beneficiary Signature or Authorized Party **Date**