

**Advanced Medical Care
290 N. Rand Road, Suite A
Lake Zurich, IL 60047**

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PATIENT AUTHORIZATION AND RELEASE FORM

Billing Policy and Patient Responsibility

I hereby acknowledge that I am receiving/about to receive health care. I understand that payment for services rendered on my behalf is my sole responsibility.

I hereby authorize Advanced Medical Care, Inc. and its designated agents to:

1. Bill my insurer and receive payment directly for all services rendered on my behalf.
2. Bill me for any amounts not paid by my insurer, including co-payments, deductibles, and non-covered services. I understand that such co-payments, deductibles and non-covered services are determined by my insurer and my insurance policy and agree to be responsible for all existing balances.
3. Bill me directly for any services denied by my insurance for pre-existing conditions.
4. Bill me directly for any services not paid within sixty (60) days from date of service for
 - a) Workman's Compensation
 - b) Personal injury claim
 - c) Auto accident
 - d) Legal action, whether contemplated, pending or adjudicated

I agree that should this account become 60 past due I will pay all financial and collection charges including reasonable attorney charges.

Accepting Assignment:

I understand that Advanced Medical Care, Inc will accept Assignment for all services provided.

Assignment is defined as the "reasonable and customary charge" for covered services. Reasonable and customary charges are established by the insurer (your insurance carrier) for the geographical area in which the service is provided. Advanced Medical Care, Inc. will accept the "assigned" value for all covered services.

Liability Release

I authorize access to all my insurance information and medical records necessary to billing the related health care services provided by Advanced Medical Care, Inc. I release Advanced Medical Care, Inc. and its agents from any and all liability claims or damages that may arise from disclosure of such information in the pursuit of payment.

I certify that I have read and have access to a copy of the patient release form. I certify that I understand the contents and my responsibilities.

Print Patient's Name _____

Signature of Patient/Representative

Date

Witness

Date