Elizabethtown Family Health Center

300 Maytown Road, Elizabethtown Pa 17022 Ph: 717-367-1430 Fax: 717-367-2895
Patrick E. Gilhool, D.O. Michael J. Leser, D.O.   Mary S. Ginder CRNP

ASSIGNMENT, RELEASE & AUTHORIZATION ACKNOWLEDGMENT

As a service to you, we will file your insurance claim if you assign the benefits to our practice. Not all insurance plans cover all services. In the event your insurance plan determines a service not to be covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
ASSIGNMENT: I assign payment of medical benefits to Elizabethtown Family Health Center & all the providers for services rendered.
RELEASE: I authorize release of necessary medical information to my insurance carrier for insurance payment.
AUTHORIZATION: I request and authorize treatments chosen by providers and employees of Elizabethtown Family Health Center. Insurance does not substitute for payment, but may allow me to be reimbursed for services rendered.
My insurance may have fixed allowances or percentages based on my contract.
Co-Pays are to be paid at time of service. We will enforce a “No-Show” fee for all missed appointments for which we were not given a 24 hour noticed during office hours
I agree to be financially responsible for all charges. I have read this information and understand it.

***SIGNATURE*:** ____ DATE: ______/______/__________

FOR OFFICE USE ONLY: **GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT**

If NOT signed, describe your good faith effort to obtain the patient’s signature on this form after having explained this form and giving it to the patient to read:

____

____

Describe why the patient would not sign this form:

____

I attest that the above information is correct:

Name:____Title:________________________________

Office Representative’s Signature: ____________________________________ Date: _____/_____/_____