* We have contracts with several carriers and will bill them directly. Youwill receive a bill for any balance due when we receive payment or denial fromyour insurance company. The balance is due within 30 days of the insurance carrier's payment.

* Dr. Creger will accept patients as Medicaid if proof of coverage is presented at time of service.

* All health plans are not the same and do not cover the same services. In the event that your insurance determines a service to be "not covered" you will be responsible for the complete charge. Payment is due within 30 days of denial.

* For all services provided to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. We will not get involved in payment disputes between custodial and non-custodial parents.

* If you are unable to pay your account in full, please make financial arrangements prior to your appointment.

I have read and understand this financial policy. I understand that I am responsible for all charges incurred regardless of insurance orthird party liability.

I authorize this office to release any information necessary to expedite insurance claims. I authorize payment of insurance benefits to Dr. Creger for services provided I authorize this office to release records to any physician that I may be referred to and any billing services for adjudication of claims. Permission is hereby granted to this office to obtain any medical records which are pertinent to this service. I hereby agree that the above information provided by me is accurate and correct.

x_____ _____ _____

Signature of patient Date Relationship (if other than patient)

_____

Signature of parent/guardian if signing for minor

NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree with the restrictions I request.I understand if I pay out of pocket for treatment, I can prohibit this health care professional from disclosing my health information to a health plan.

_____ _____

Signature of Patient or Legal Representative Witness

_____ _____

Date Date