HIGHLAND CLINIC
A Professional Medical Corporation

_____
Patient Name (Please Print)
(Receptionist Only)

_____ Med. Rec. # _____
Responsible Party (Please Print)
(Receptionist Only)

Assignment of Benefits

I authorize payment of medical benefits under any insurance policy(ies) or other settlement, if any, to Highland Clinic, A.P.M.C., for any medical services.

INDEMNITY INSURANCE ASSIGNMENT OF BENEFITS:

I agree to pay Highland Clinic, A.P.M.C., for all charges in excess of the amounts paid by my insurance policy(ies). I understand it is my responsibility to determine whether your services are covered by my insurance policy(ies). A photostatic copy of this authorization shall be considered as valid as the original.

MANAGED CARE ASSIGNMENT OF BENEFITS (HMO/PPO):

I agree to pay Highland Clinic, A.P.M.C., for copayments, deductibles or charges for services which are not covered under my Member's Benefits contract.

Authority to Release Information

Highland Clinic, A.P.M.C., is authorized to release information or facts, including substance abuse or mental diagnosis to my insurance carrier or their representative for their use in determining a claim for payment on my behalf or for use in any audit of the records of Highland Clinic, A.P.M.C. by any insurance carrier, HMO or third party payor. A photostatic copy of this authorization shall be considered as valid as the original.

Disclosure Statement and Billing Information

I hereby acknowledge that I have read the Authority to Release Information and Billing Rights (on the reverse) and agree to all terms herein and further acknowledge receipt of copy of disclosure statement.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations as long as I pay for the services in full. If I do not pay in full, entity is not required to abide by such restriction.

I wish to allow the following individuals access to my health information:
(A separate authorization will have to be filled out for actual copies of the Medical Record)

_____

_____

_____

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Responsible Party
(if patient is a minor)

Your Billing Rights - Keep this Notice For Personal Use

This notice contains important information about your rights and our responsibilities under The Fair Credit Billing Act.

Notify Us In Case of Errors or Questions About Your Bill

If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write us (on a separate sheet) at the address listed on your bill. Write to us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

Your Rights and Our Responsibilities After We Receive Your Written Notice.

We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we did not make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.

If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within ten days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And, we must tell you the name of anyone we report you to. We must tell anyone we report you to that the matter has been settled between us when it finally is.

If we do not follow these rules, we cannot collect the first $50.00 of the questioned amount, even if your bill was correct.

If you have any questions about this notice or any aspect of the statement, please let us know.

FINANCE CHARGE: The Finance Charge is computed as a periodic Rate of 1 ½ % per month which is an Annual Percentage Rate of 18% applied to the 90 day balance after deducting payments and credits appearing on this statement. For balances less than $50.00 there will be a minimum Finance Charge of 50¢.

MANAGED CARE INSURANCE:

Highland Clinic has agreements with many Managed Care Insurance Companies and will abide by the agreement including Billing and Collecting. The patient will be responsible for any co-pays, deductibles or non-covered services as directed by their Managed Care Plans.

It is the patient's responsibility, before making an appointment, to confirm with your Managed Care Carrier as to whether or not Highland Clinic physicians are providers and/or In-Network providers for their plan. The patient will be responsible for payment of their services if Highland Clinic physicians are not providers or In-Network providers for their plan.

COMMERCIAL INSURANCE:

As a courtesy to our patients, Highland Clinic will file your insurance claims. Accurate insurance information and a copy of the insurance card must be supplied by the patient. Although every attempt is made to help patients with filing for insurance benefits, **the patient has final responsibility for payment of services rendered.** When your account has been paid in full, if an over payment occurs, Highland Clinic will refund the patient or the insurance company within a reasonable length of time.

Services are payable upon date performed or upon receipt of monthly statement if credit has been established. If extended terms are required on larger balances, the Credit Office will establish a payment schedule. For your convenience, we accept VISA, MASTERCARD and DISCOVER.

In the event it becomes necessary to refer the account to an attorney or outside collection agency, you hereby agree to pay attorney fees of no less than 33.33% of the amount due together with all court costs and judicial interest.

HIGHLAND CLINIC
A Professional Medical Corporation
1455 E. Bert Kouns Industrial Loop
Shreveport, LA 71105
318-798-4500

All Accounts Are Due In Full Upon Receipt Of Statement