Deanne M. Unger, RNC, MS, FNP Diana A. Stephens, RN, MSN, GNP Robin A. Pingeton, RN, MSN, FNP

Facility Name_____ **Patient Name**_____

I hereby authorize the following:

a) I fully understand that **insurance does not cover everything and I may be held financially responsible for services rendered by a Nurse Practitioner.**
b) I authorize examination and treatment for this and the entire following physician or Nurse Practitioner visits performed by SGHG.
c) I authorize SGHG to obtain records from other sources as may be necessary for the diagnosis and treatment.
d) I authorize to release any medical information necessary to process insurance billings.
e) I authorize payments of insurance benefits otherwise due to me to be made directly to SGHG.
f) I authorize assignment of insurance benefits to SGHG.
g) I have read and reviewed SGHG's Notice of Privacy Practices (HIPAA).
h) I shall be personally responsible for **supplying accurate and current insurance information.**
i) I fully understand that I am financially responsible **for all charges and deductibles not covered by insurance.**
j) I fully understand that **Blue Cross/Blue Shield does not contract with Nurse Practitioners** and I may be held responsible for charges if I have BCBS policy.

Invoices and correspondence should be sent to:

☐ **Check here if you would like to receive invoices by email** **Email Address:** _____

Billable/Responsible Party Name: _____ Relationship: _____

Address: _____ Phone 1: _____

City: _____ State: _____ Zip Code: _____ Phone 2: _____

Responsible Party/Patient Signature_____**Date**_____