BP GAMMA MEDICAL
SUPPLIES AND EQUIPMENT

7118 Geoffrey Way, Suite P
Frederick, MD 21704

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to **BP Gamma Medical** for services furnished me by **BP Gamma Medical**. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **BP Gamma Medical** accepts the charge determination of the Medicare carrier as the full charge, and 1 am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **RELEASE OF INFORMATION**: **BP Gamma Medical** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to **BP Gamma Medical** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **BP Gamma Medical** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.

3. **OTHER INSURANCE**: I understand that **BP Gamma Medical** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that **BP Gamma Medical** has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individual obligated to pay the full charges of all services rendered to me by **BP Gamma Medical** if I belong to a plan that does not appear on the above mentioned list.

4. **NON-COVERED SERVICES**: I understand that **BP Gamma Medical** contracts with health care service plans (i.e. HMOs, PPOs) that state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **BP Gamma Medical** to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by **BP Gamma Medical**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **BP Gamma Medical** for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **BP Gamma Medical**. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to **BP Gamma Medical**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

6. **PRIVACY PLAN**: I agree that I have been given the opportunity to read and receive a copy of the **BP Gamma Medical Notice of Privacy Practices**.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____
Patient or Responsible Party (Print) Date of Birth

_____ _____
Patient or Responsible Party ** Signature Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:

_____(e.g. state law, court order, etc.)