JACKSONVILLE IMPOTENCE TREATMENT CENTER.

AUTHORIZATIONS AND ACKKNOWLEDGMENTS

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or you payment responsibility.
All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type **of picture identification to remain** a permanent part of your chart.

INSURANCE INFORMATION

If you are covered by Medicare, Champus or any other managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit If we do not participate with your insurance company, you will be responsible for full payment at the time services are rendered.
All **self-pay** patients are expected to pay **for services in full at the time services are rendered. Unless otherwise detailed. We will file with** all insurance plans for our professional fees.
hi the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
Please advise the office personnel of any changes in your insurance or mailing address.
Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

WORKERS' COMPENSATION

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

COMPLETION OF FORMS

Jacksonville Impotence Treatment Center reserves the right to charge **a nominal** fee for completion of disability and/or Family Medical Leave forms. Your insurance company will not pay for completion of forms.

Thereby authorize .TITC to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim, I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the insurance information is currently correct,

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Responsible Party Signature	Patient's Name (Please Print)	Date

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the Jacksonville Impotence **Treatment** Center (JITC)Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at IITC, / authorize JITC to use and disclose information from and **release** copies of my (the patient's) medical records in accordance with RTC policies and privacy practices, which are summarized in the NM', including disclosure to my (the patient's) past, present and future healthcare providers.

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Patient Signature	Date

METHODS OF PAYMENT: CASH, CHECK, 'VISA and MASTERCARD