Payment Authorization

Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
Blairsville, GA 30512

INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. You are required to pay a percentage or a copay at the time of service. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or authorization may result in lower or non-payment from the insurance company.

SELF PAYMENT: You are required to pay for services rendered in full at the time of service, unless other payment arrangements have been made before the appointment.

PAST DUE AMOUNT: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs.

WAIVER OF CONFIDENTIALITY: You understand that if this account is submitted to an attorney or collection agency, the fact that you received treatment in our office may become a matter of public record.

RETURNED CHECKS: There is a fee (currently $30.00) for any checks returned to the bank.

We ask all patients to show their driver's license and insurance membership card so that we may make copies of them.

I, _______________________________ hereby authorize Joseph A. Rutz, Jr. M.D. to furnish information concerning my present illness necessary for processing claims on my behalf. I direct the insurer to pay, directly to the physician, all benefits due for services rendered. I am aware that I am personally responsible for all charges for services rendered me regardless of insurance.

Patient's Name: ____
(Please Print)

Signature: ____ Date: ______________________