Center for Integrated Health Care

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**Authorizations and Policies**

**Insurance Company Assignment and Release**

I, the undersigned, do hereby assign directly to The Center for Integrated Health Care, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance or myself for any of my dependents. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance claim submissions for myself or my insured dependents.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Treatment and Financial Responsibility**

I, the undersigned to hereby give authorization to the medical staff of The Center for Integrated Health Care, PC to evaluate, treat, order lab and/or other tests and to perform office procedures. I accept full financial responsibility (regardless of insurance payment or non-payment) for all charges incurred by myself or any person(s) I am responsible for (i.e. minor child, foster child, grandparent, and spouse, other…). Account balances must be cleared (no balance due) prior to scheduling another appointment unless prior arrangements have been made.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Policy**

Patients are requested to give notice as soon as possible when cancelling or rescheduling an appointment in order for the appointment slot to be available for someone else. Appointments cancelled with less than 24 hours’ notice or missed appointments will be charged a fee between $25-$75 depending on the appointment type and number of previously missed appointments. If a patient has an excess number of missed appointments or late cancellations he/she may be dismissed as a patient from the practice. An afterhours voicemail is provided for cancellations. By signing below I agree to the appointment policy and agree to pay any fees from missing my or my dependent’s appointment.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_