Patient Chart Number _____

Galichia
MEDICAL GROUP

ASSIGNMENT OF BENEFITS – FINANCIAL RESPONSIBILITIES

I authorize my insurance carrier to release information regarding my coverage to Galichia Medical Group.

My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to Galichia Medical Group. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Galichia Medical Group.

I understand that I am responsible for all charges regardless of insurance coverage and acknowledge that, in the event the insurance company does not pay in a timely manner, I will pay in full for all incurred charges. I also understand that as a courtesy to me, Galichia Medical Group will file my incurred charges with my primary & secondary insurance carriers. Amounts not covered by my insurance are my responsibility. I understand that it is my responsibility to ensure that Galichia Medical Group has accurate, up-to-date information on my insurance coverage.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Signature of Patient /Patient Representative Date

_____
Relationship to Patient

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Galichia Medical Group's Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____
Signature of Patient / Patient Representative Date

_____
Relationship to Patient

Form # 1042 – NEW PATIENTS ONLY