YOUR SIGNATURE IS REQUIRED FOR THE PROCESSING OF INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

THE NON-MEDICARE PATIENT:

I hereby assign to the Provider any and all benefits from any insurance plans or any other protection maintained by the patient and/or for the patient's behalf or benefit and authorize and direct such benefits to be paid directly to the Provider for services provided to the patient. I certify that the information given by me to the provider in applying payment under insurance plans, Medicaid programs(straight only), or other protection is correct and complete. I authorize release of all records to act on this release assignment.

THE MEDICARE PATIENT:

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Victoria J. Mondloch for services furnished to me by this provider. 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 benefits or the benefits payable for related services. I certify that the information given by me to the provider in applying for payment under the Medicare program is correct and complete. I authorize release of all records required to act on this release and assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

ALL PATIENTS:

OUR OFFICE UTILZES MULTIPLE CLINICAL LABORATORIES TO PROCESS OUR SPECIMENS. IT IS YOUR RESPONSILBILITY TO NOTIFY US IF YOUR INSURANCE REQUIRES YOU TO USE A SPECIFIC LABORATORY FOR PAPs OR BLOOD WORK. IF YOU ARE IN NETWORK FOR LAB ONE PLEASE LET US KNOW AT THE TIME OF YOUR VISIT, OTHERWISE, PAPs AND TISSUE SPECIMENS WILL BE SENT TO WAUKESHA MEMORIAL HOSPITAL'S LAB UNLESSS OTHERWISE NOTED BY YOU.

WE CONTACT YOUR INSURANCE COMPANY REGARDING COVERAGE FOR PHYSICIAN, LABORATORY OR PATHOLOGY SERVICES THAT MAY COINCIDE WITH YOUR VISIT. THIS IS NOT A GUARANTEE OF PAYMENT UNTIL YOUR CLAIM IS PROCESSED.

PLEASE CALL YOUR INSURANCE COMPANY BEFORE APPOINTMENTS FOR QUALIFICATION OF YOUR BENEFITS AND COVERAGE WITH OUR CLINIC.

ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE.

VENIPUNCTURE (BLOOD DRAW) IS AVAILABLE ON-SITE FOR YOUR CONVENIENCE. THIS FEE IS $25.00 AND DUE AT THE TIME OF SERVICE.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, INCLUDING ANY AND ALL LAB CHARGES, OFFICE CHARGES, AND ANY TESTING THAT MAY BE ORDERED BY MY PHYSICIAN. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND AND AGREE TO THE TERMS STATED.

DATE_____
SIGNATURE_____