PREMIERE MEDICAL CENTER · 4418 Vineland Ave · Suite 102 · Toluca Lake · CA · 91602 · Phone · (818) 842-7145 · www.pmcburbank.com ·

OUR POLICIES

Premiere Medical Center prides itself on one-on-one, personalized patient care.
To keep our commitment to excellent service, we ask that you review our policies.

Please sign and date at the end of this form to confirm that you understand and will follow Premiere Medical Center's polices.

ASSIGNMENT OF BENEFITS

I request and authorize that all insurance benefits of Medicare, major medical and/or private insurance be paid on my behalf to Premiere Medical Center, Inc. of Burbank, CA. This "assignment of benefits" is to remain in effect until revoked by me in writing. A photocopy of this statement shall be considered as valid as the original.

RELEASE OF MEDICAL INFORMATION

I further authorize Premiere Medical Center, Inc. of Burbank, CA to release any and all medical information necessary to process my claim and to secure payment.

PAYMENT AGREEMENT

I understand that I am responsible for any and all charges not covered by my insurance, including any deductible and/or co-payment.

Premiere Medical Center, Inc. of Burbank, CA will make every effort to assist our patients in understanding the scope of your insurance benefits and the method of determining your coverage. Nevertheless, it is ultimately your responsibility to understand your policy, its benefits, and the obligations it places on you. It is not the responsibility of Premiere Medical Center to verify your insurance coverage (this includes information as far as our physicians in our out-of-network status) or determine which services are or are not covered. Additionally, it is your responsibility to ensure that laboratory tests, x-rays, and consultations are covered by your insurance. Therefore, if your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly.

I have read and understood the above information and accept full responsibility if my insurance does not pay for services rendered.

_____ _____
Signature Printed Name

_____
Date

_____
Patient's name, if signing as a responsible party

MISSED APPOINTMENTS / CANCELLATIONS

I understand that appointments are pre-arranged and it is my responsibility to keep the appointment or cancel with a minimum of ***48 hours*** notice. I understand that I will be billed ***$40.00*** for any missed appointments, or those not cancelled at least 48 hours before.

_____
Signature

_____
Date