



Dannielle Harwood, M.D.  
Women's Health & Family Medicine  
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PATIENT NAME (PRINT): \_\_\_\_\_

BENEFICIARY NAME (PRINT): \_\_\_\_\_

**FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL RECORD(S)**

**ALL Patients' / Authorized Person's Signature Required:**

Insurance Authorization and Assignment:

"I authorize that payment be made directly to the doctor for all medical, surgical, and hospital benefits entitled to me. I understand that I am financially responsible to the doctor for charges not covered by this assignment and/or remaining (outstanding) balances."

(Guarantor Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

**ALL Patients' / Authorized Person's Signature Required:**

"I agree that if I do not pay my full account balance within 30 days, Dannielle Harwood, M.D. A Professional Medical Corporation, may refer this account to its collection agency, and/or attorneys, for collection efforts. I will also be responsible for, and agree to reimburse Dannielle Harwood, M.D. A Professional Medical Corporation for any and all reasonable collections fees (currently 25% of unpaid balance due), including legal fees, filing fees, interest, service cost, and disbursement incurred as a result of the collection efforts."

(Guarantor Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

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**Medicare Patient or Authorized Person's Signature:**

"I request that payment of authorized Medicare benefits be made either me or on my behalf to the name of provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. 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 these benefits payable for related service.”

**Medicare/Medigap Patient (Secondary Insurance) or Authorized Person's Signature:**

“I request that payment of authorized benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) \_\_\_\_\_ any information needed to determine these benefits payable for related services.”

(Guarantor Signature) \_\_\_\_\_ (Date) \_\_\_\_\_