

Daniel L. Munton, M.D. PA

Office Procedures

Referrals: If your insurance requires a referral from your primary care physician, it is your responsibility to obtain one before you can be seen. If you do not get one, your appointment will be rescheduled. There are no exceptions.

Financial Policy: All co-pays, deductible amounts, and non-covered services for office visits are due at the time of service. If you have any questions, please call our office at 325-698-4545 ext 213.

Insurance: Please bring your current insurance card and picture ID. We will make a photocopy of both your insurance card and picture ID. We will file your insurance for you. All charges will be the patient's responsibility. Any unpaid insurance claims after 60 days will be billed to the patient. Regardless of insurance, payment remains your personal responsibility.

Minors: a parent or guardian who is legally allowed to give medical consent must accompany all minors under the age of 18.

I have read and understand the procedure of the office of Daniel L. Munton, M.D

Signature of Patient or Parent/Legal Guardian if under 18 years of age Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signature of Patient or Parent/Legal Guardian if under 18 years of age Date

Release of Information

I hereby authorize my physician at Daniel L. Munton, M.D. PA to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the insurance, Medicare, or any other health plan or its agents, any information needed to determine these benefits or the benefits payable to related services. Please consider this signature as authorization to release my confidential medical records.

Signature of Patient or Parent/Legal Guardian if under 18 years of age Date

Release of Protected Health Information

If Necessary, my Protected Health Information may be released to the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*If you would like anyone other than yourself to be able to call our office and to discuss your account or medical information you must print their name in the space provided. This does include spouses.

Signature of Patient or Parent/Legal Guardian if under 18 years of age Date

Daniel L Munton, MD PA

Agreement to Pay for Medical Services

Your signature on this document verifies that there is an understanding that there could be a patient portion incurred with each visit. As a courtesy, we do file private health insurance; however, **there may be a patient portion to be paid for left over costs after the services are rendered.** These could include but are not limited to calendar year deductibles, coinsurance, and non-covered services.

PLEASE NOTE: If your account balance is more than 120 days past due and you do not have a financial agreement in place, you will be turned over to a collection agency.

I understand that I am responsible for any collection fees and/or attorney fees.

Signature of Patient or Parent/Legal Guardian if less than 18 years of age

Date