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**PAYMENTS/MEDICAL INSURANCE:**

Payments for medical care received is due at the time of service. All monthly statements are due upon receipt and payable in full. We are not a party to agreements between you and your insurance company and regardless of the action of your insurance company, payment for services is your responsibility. If special financial plans are needed, we will work with you to make arrangements for payments. If no satisfactory arrangements are established and a bill remains unpaid, the account is assigned to a collection agency.

I, the patient and/or responsible party for payment, do authorize the release of all medical information necessary to process any insurance claim filed on my behalf and hereby request direct payment to the UND Center for Family Medicine of authorized insurance or Medicare benefits payable to me or for my benefit.

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(Signature of Patient, Parent/Responsible Party)

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(Date)

**Statement to Permit Payment of  
Medicare Benefits to Provider,  
Physician, and Patient**

**Name of Beneficiary**

**Health Insurance Claim Number**

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I request that payment of authorized Medicare benefits be made either to me or in my behalf to Bismarck Center for Family Medicine any services furnished me by this provider. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Statement to Authorize Medicare Participating  
Providers to Request Medicare to Send Payment  
Information and to Receive the Beneficiary Payments  
from the Medigap Insurance Companies**

**Name of Beneficiary**

**Health Insurance Claim Number**

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I authorize Medicare to send "Explanation of Your Medicare Part B Benefits" information to my Medigap Insurance and benefits to be made in my behalf to Bismarck Center for Family Medicine for any services furnished to me by this Medicare Participating Provider until further notice. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents.

Medigap Insurer \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_