Finger Lakes COMMUNITY HEALTH

Name/Nombre: ________________________ **DOB/ Fecha de Nacimento:**_________

Billing Consent

Assignment of Benefits

I authorize **Finger Lakes Community Health** to submit claims on my behalf to my insurance provider. I also authorize payments to be made directly to **Finger Lakes Community Health** for services provided to me or my dependent(s). A copy of this authorization may be used as a valid signature for the assignment of benefits.

I understand that I will be responsible for paying the full balance after receiving services, if I choose not to assign payment to the facility by changing my Primary Care Physician (PCP).

Authorization for Release of Information for Billing Purposes

I understand that **Finger Lakes Community Health** may need to share my health information for billing purposes with the insurance carrier. The information shared is generally limited to what is necessary for the claim, such as the diagnosis, treatment provided, and relevant medical history.

Credit Card Usage

I understand that **Finger Lakes Community Health** will not require me to pre-authorize a credit card payment before services are provided. If I choose to use a credit card for payment, I acknowledge that I am waiving my rights regarding healthcare debt under New York State law (Article 49A of the New York Public Health Law), which states that healthcare debt is not reportable to credit agencies. Using a credit card will remove this protection and any unpaid debt may be reported to credit agencies by my credit card provider.

Financial Responsibility

I understand that I am responsible for the payment of services provided by **Finger Lakes Community Health.** I am also responsible for any applicable insurance co-payments, deductibles, or non-covered services unless otherwise covered by financial assistance or by the sliding fee scale program (a discount program) after treatment has been provided.

Signatures - Patient (or Parent/Guardian if Minor):

I understand that my consent will be in place as long as I am a patient of Finger Lakes Community Health or until I rescind my consent in writing and deliver it to a Finger Lakes Community Health center. By signing below, I acknowledge that I have read, understood, and agreed to the terms outlined in this Billing Consent.

________________________________ ________________________________ ______________

Patient/Parent/Guardian Name (Print) **Patient/Parent/Guardian Signature** **Date**