CANCELLATION POLICY

In consideration of your fellow patients, **please contact our office at (432) 683-8516** as soon as possible if you need to cancel or reschedule your appointment. We require that you call **at least 24 hours in advance**, and calling early in the day is appreciated. Appointments are in high demand, so your early cancellation will give another patient the opportunity to access timely medical care. If you do not reach the receptionist, you may leave a detailed message with the answering service. Please be sure to leave us your phone number and let us know the best time to return your call.

There will be a $50.00 fee for either failing to show up for a scheduled appointment or canceling a scheduled office visit less than 24 hours in advance. Please be sure to cancel more than 24 hours in advance to avoid these fees.

As a courtesy to our other patients, if you are more than fifteen (15) minutes late for a scheduled office visit or procedure, you may be asked to re-schedule, in which event we will assess the applicable cancellation fee against your account. To avoid these fees, be sure to show up on time or cancel more than 24 hours in advance.

NO-SHOW POLICY

It is the policy of Midland Medicine, PA to monitor and manage appointment no-shows. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. We reserve the right to dismiss from the practice a patient who is a no-show on more than three occasions.

I have read and understand the Cancellation and No-Show Policies of Midland Medicine, PA and agree to comply with them to the best of my ability.

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Patient/Guardian/Personal Representative Signature Date

Assignment of Insurance Benefits

I hereby authorize Midland Medicine, PA to file claims with my insurance company and to receive payment for my medical care and/or procedures. Midland Medicine, PA has my permission to release any information required to secure payment of benefits. I authorize the use of my signature below in connection with all insurance submissions. I further authorize payment directly to Midland Medicine, PA of all insurance benefits related to my care. I understand that I am responsible for any co-payments, co-insurance, or deductibles due at the time of any and all office visits or procedures. I also understand that I am financially responsible for all charges not covered by my insurance benefits for services rendered on my behalf. I further understand that bills from Midland Medicine, PA, Explanations of Benefits ("EOBs") pertaining to reimbursement for my care, and other correspondence from this medical practice concerning my account may be sent under the name of, or make reference to, Midland Medicine, PA and/or its Member Physicians, including without limitation J. Hunter Atkins, M.D. I will take action on these items accordingly.

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Patient/Guardian/Personal Representative Signature Date

Medicare Authorization

I request that payment of Medicare benefits be made to Midland Medicine, PA on my behalf for any services furnished by Midland Medicine, PA or under its direction. I understand that my signature below requests the assignment of payment for my medical care and authorizes the release of medical information necessary to pay any related claims. I acknowledge that in Medicare assigned cases, Midland Medicine, PA agrees to recognize the allowable charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the difference between the allowable charge and the amount paid by the Medicare carrier pursuant to Medicare regulations. I further acknowledge that although I am a Medicare beneficiary, Midland Medicine, PA may recommend certain procedures or treatments that are either not covered by Medicare or are not covered for use in the manner Midland Medicine, PA has recommended. In such an event, Midland Medicine, PA will undertake its best efforts to consult with me concerning the medical necessity and the unlikelihood of reimbursement for the procedure or treatment in question. I may be asked to sign certain documentation that the Medicare Program requires in such circumstances. I recognize that if I elect to proceed with the procedure or treatment in such an event, I will be personally and fully responsible for payment.

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Patient/Guardian/Personal Representative Signature   Date