Philip Chironis, M.D. Medical Corporation
Treatment Agreement Form

Patient Name: ____

PRIVATE INDEMNITY INSURANCE PLANS: As a courtesy, this office provides insurance billing services at no charge. However, you are personally responsible for payment of all service(s) rendered and we will look to you for payment if your insurance company does not pay in a timely manner.

HEALTHPLAN MEMBERS (PPO, EPO, POS, HMO, ETC.): As specified by our contract with your insurance carrier, all billing will be done for you by this office. However, you are personally responsible for all applicable deductibles, co-insurance, co-payments and any services denied as not a covered benefit by your health plan carrier.

_________________ Initials

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY PHILIP N. CHIRONIS, M.D., MEDICAL CORPORATION:

I authorize the release of any medical information necessary to process my insurance claim(s).
I authorize payment of medical benefits to PHILIP N. CHIRONIS, M.D., MEDICAL CORPORATION for services rendered.

Signed____ Date ______________________

AUTHORIZATION TO TREAT AND AGREEMENT TO TERMS OF PAYMENT:

I hereby give PHILIP N. CHIRONIS, M.D., MEDICAL CORPORATION, authorization to care for **my** medical needs and/or those of my dependants. In consideration of these services to be rendered to the patient, the undersigned responsible party agrees to pay for these services upon completion of billing and further agree that should he/she default in paying for those services within 90 days and three statements, he/she may be sent to collections and responsible to cover any agency costs, including reasonable attorney's fees.

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Signature of Patient or Legal Guardian Date