Michael K. Laidlaw MD, Inc.
5180 Grove St.
Rocklin, Ca 95677
(916) 315-9100
(916) 315-0141 fax

INSURANCE AUTHORIZATION AND FINANCIAL POLICY

1. I hereby authorize Michael K. Laidlaw, M.D. to furnish information to insurance carriers concerning my medical condition and treatment.

2. I hereby assign to Michael K. Laidlaw, M.D. all payments for medical services rendered by him that may otherwise be paid to me.

3. For Medicare patients: I request that payment of authorized Medicare payments be made to Michael K. Laidlaw, M.D. on my behalf.

4. I understand that all coinsurance, copayments, and deductibles need to be paid by me. To facilitate payments I am also completing the separate Coinsurance and Deductible Policy form which contains my credit card data.

5. I acknowledge that this authorization for assignment of benefits will continue indefinitely unless revoked in writing by me.

6. I understand co-payments are due at the time of service.

7. Michael K. Laidlaw, M.D is not contracted with ***Medi-Cal.*** The patient is responsible for all copay and coinsurance at the time of visit.

I have read and understand Michael K. Laidlaw, M.D.'s Financial Policy and I agree to be bound by its terms. I understand that it is my responsibility to know and understand my insurance benefits including co-payments, deductibles, and non-covered services.

_____ _____
Patient Signature Date

_____
Please Print Patient's Name

I have read and understand the **Notice of Privacy Practices** of Michael K. Laidlaw, M.D.

_____ _____
Patient Signature Date