

**Agreement of Financial Responsibility  
&  
Assignment of Benefits and Release of Information**

Infectious Disease Specialists of Atlanta, PC

**Responsibility for Payment:**

I understand that I, personally, am financially responsible to Infectious Disease Specialists of Atlanta, 2665 North Decatur Road, Suite 330, Decatur, GA 30033 for charges not covered by the assignment of insurance benefits.

**Assignment of Insurance Benefits:**

I hereby authorize payment of medical benefits directly to the physician or supplier to cover the costs of the care and treatment rendered to myself or my dependent.

**Medicare Benefits:**

I certify that the information given by me in applying for payment under the Social Security Administration and the Centers for Medicare and Medicaid Services is correct. I authorize any holder of medical or other information about me to release any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**Release of Information:**

I hereby authorize and direct Infectious Disease Specialists of Atlanta, and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

**Collection of Fees:**

I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. I understand that these additional fees will be my personal responsibility.

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**Signature of Patient/Guardian**

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**Date**

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**Patient Name (please print)**