



**Patient Financial Consent Form**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Consent & Assignments – Please Read before Signing**

I understand that, if appropriate, Account Resolutions will bill my Insurance Plan for services to be rendered by CCC Diagnostics, LLC. However, I also understand that pursuant to the Maryland Law, Account Resolutions is authorized to bill me directly under the following conditions.

**MEDICARE:** I authorize my holder of medical or other information to release any information needed for this or a related Medicare claim to the Social Security Administration & Health Care Finance Administration or its intermediaries or carriers. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any insurance deductibles and co-insurance.

**LEGAL ASSIGNMENT:** The undersigned expressly agrees that if, upon default, this matter is referred to an attorney for collection, the undersigned agrees to pay for any and all court cost, incurred therewith.

**INSURANCE ASSIGNMENT:** I authorize and assign payment directly to CCC Diagnostics, LLC and authorize release of medical information necessary to process the claim. I further understand that I am financially responsible for charges not covered by my insurance. I give permission to CCC Diagnostics, LLC and Account Resolutions to bill my insurance company for the amount of this test, and I understand that if the service is not a covered benefit that I will be financially responsible for all charges in full.

**PATIENT MANAGED CARE:** I understand that if service is not a covered benefit and that without an authorization/referral form from my HMO/IPA/PPO, I will be financially responsible for charges I incur in full.

I certify that all information provided by me in this package is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I further acknowledge that I have read and understand all of the above and agree to it.

I certify that I have read and understand the foregoing agreement. I will notify CCC Diagnostics, LLC within 10 business days of any changes to the information including any changes/challenges to my insurance coverage, etc. If my insurance does not cover this test for any reason, I acknowledge and agree that I will be held responsible for the amount owed to CCC Diagnostics, LLC to be paid in full within 20 days of test completion.

Responsible Party, Patient, Spouse or Guardian:

Print Name: \_\_\_\_\_

Signature of Patient or Guardian/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

**Attention Physicians**

Please fax all material to 410-633-4502 and submit original signed documents and other required materials to:  
CCC Diagnostics, LLC, P.O. Box 7467, Baltimore, MD 21227-7467