Ransom International Partners

Ransom International Partners is a medical billing and claims service specializing in American and British medical insurances. We assist international medical providers with billing American and British health insurance companies complying with HIPAA guidelines.

1. **RELEASE OF INFORMATION**: I hereby authorize Ransom International Partners 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.

2. **COLLECTION 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. This includes but is not limited to late fees, collection agency fees, court costs, accrued interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

3. **BILLING OFFICE**: If you have questions in regard to any of your billing statements, our accounts receivable staff at Ransom International Partners medical billing is available to assist you under the number 06371-737 6112.

4. **SELF PAY PATIENTS**: I understand that full payment is due upon receipt of invoice.

5. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign, transfer, and set over directly to this clinic sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Ransom International Partners (RIP) billing company to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information. I authorize this clinic and Ransom International Partners to release all medical information requested by my health insurance carrier, other physicians or providers, and any other third-party payers.

6. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible for charges not covered by the assignment of insurance benefits.

E-MAIL ADDRESS: _____

PHYSICAL ADDRESS: _____

APO ADDRESS: _____

CELL PHONE NUMBER: _____

PERMANENT STATESIDE ADDRESS: _____

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. I consent to reminders of my open statements to be sent to me via e-mail, European address or to my permanent stateside address due to relocation.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Patient Name (Please Print)

RANSOM
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