Ronald L. Renard, MD. Inc
1505 Victor Avenue
Redding, CA 96003
530-226-5325

Financial Agreement & Release

I hereby assign all medical benefits to which I am entitled to Ronald L. Renard, MD. Inc: a medical corporation. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. _____ Initial

I understand my medical insurance will be billed as a courtesy, and I am financially responsible for all charges not paid by my insurance. I understand that I am financially responsible for claims that are denied or delayed in processing by my insurance. ____initial

I understand that **all co-payments are due at the time of service; all deductibles, if not already met will also be due at the time of service.** I understand that full payment is due upon receipt of billing statement unless credit arrangements are agreed upon in writing. I understand that my account may be turned over to an outside collection agency after 60 days past due.
____initial

I acknowledge that this office will keep a copy of my government issued photo ID (driver's license) on file and I may be requested to show it when asked, in keeping with federal privacy laws. (This is to protect your identity and medical records.)
____initial

I understand that Dr. Renard is **NOT a Medi-Cal or Partnership provider.**
____initial

I understand that I can obtain access to my Patient Health Record (PHR) for by Ronald L. Renard, MD, Inc, if I so choose. To do this, I must give Dr. Renard **my valid e-mail account**. I further understand that I am solely responsible to protect the password to my PHR account and I will not give access to anyone who I don't wish to have access to my medical records. **This patient portal is not available for anyone under the age of 18. I also understand that I cannot obtain an account for anyone other than myself.**

I would like access to my PHR _____initial: My valid e-mail address is: _____
Print Clearly

I already have a PHR account with Dr. Renard _____initial

I do not wish to activate an account at this time _____initial

I hereby authorize Ronald L. Renard, MD., Inc. to release any medical information necessary facilitate claims processing by my insurance company.

Date: _____

Printed Name: _____

Signature: _____

If patient is a minor,
Relationship to patient: _____