

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize Dr. _____ and his/her physician extenders to conduct and direct my medical care while I am a patient at Family Medical, P.C. I also authorize Family Medical, P.C. staff, directed by my physician, to give medications, perform diagnostic procedures and provide other care which, in the judgement of my doctor, is required for my best care and treatment.

ASSIGNMENT OF BENEFITS

I direct and authorize payment directly to my physician for all monetary benefits available to me. It is expressly understood and agreed that acceptance by the said hospital, of benefits under this policy, shall in no way operate to release the person responsible for payment of the services referred to herein from his/her obligation to pay for all charges not covered by my insurance policy or in excess of said policy limits.

GUARANTEE OF PAYMENT

For value received, the undersigned hereby unconditionally guarantees the prompt payment of all its charges, hereby agreeing to pay all costs and expenses incurred in enforcing this guarantee.

In the event the patient or guarantor fails to comply with their obligation herein, each consents to the disclosure of their identity and any other necessary information relating to service rendered to the patient by the attending physician to any collection agency or attorney at law, for the purpose of enforcing the patient's or guarantor's obligation to the health group and the re-disclosure of such information by the collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient confidentiality by the health group.

RELEASE OF WRITTEN AND/OR VERBAL INFORMATION FOR BILLING AND UTILIZATION REVIEW PROCESS

I authorize my physician to release written and/or verbal information from my medical record, as necessary, to process my insurance claims and for utilization review when justification for treatment or continued treatment is required.

I have read the above statements or have had them read and explained to me.

X

Patient Signature (Date)
Patient/Legal Guardian

Witness

MEDICARE ASSIGNMENT AND AGREEMENT TO PAY MEDICARE NON-COVERED CHARGES

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration and/or its intermediaries and/or carriers any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing these services, or authorize the above to submit a claim to Medicare for payment to me. I understand Medicare Participating Physicians have been advised by the Health Care Financing Administration (HCFA) that services provided to Medicare Beneficiaries, which are determined by HCFA to be unnecessary, will not be paid for by Medicare. The Physician may not collect for these services from the patient, unless prior notification has been given. I request that this authorization apply to the period from _____ to _____.

Beneficiary Representative Payee Signature

Date

Due to HIPAA regulations we are unable to release any information regarding you, including billing, test results, etc., even to a family member. If you would like to give us permission please list those names below and sign.

Signature