Patient Name:_____ Date:_____ Facility: _____

I hereby authorize this medical facility to apply for Medicare/Medigap, and other health insurance benefits (if applicable, No-Fault and Worker's Compensation) on my behalf. I request that payment of Blue Cross and Blue Shield and other insurance carriers be made directly to the above-named provider. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information and records about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, and any and all other information needed to determine the benefits payable for related service(s).

I hereby authorize payment of Medicare/Medigap benefits be made on my behalf to the above-named provider. I release any holder of Medicare/Medigap information about me to my insurance carrier(s) necessary to determine benefits payable for related services.

I hereby authorize this medical facility and its associates to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, claims adjuster, or attorney if applicable.

_____ _____

Signature of Patient or Guardian Date

FINANCIAL POLICY

If correct and current medical insurance information is provided at the time of service, a claim will be submitted to your insurance company. You will be responsible for all co-payments, coinsurances and deductibles not met for the year as well as any non-covered services under your health plan. With the exception of co-payments, which are payable at the time of visit, you will be billed for any of the aforementioned fees. Payment is due upon receipt of a billing statement. If the correct insurance information is not presented at the time of service, you will be responsible for the full amount of charges incurred. If you do not have medical insurance, financial arrangement must be made prior to services rendered. Otherwise, full payment is expected at the time of service. We will attempt to resolve all past due balances amicably, but non-payment will be subject to the collection process.

_____ _____

Signature of Patient or Guarantor Date

I have reviewed all previously documented information on the registration form and acknowledge that it is complete and accurate.

_____ _____

Signature Date