Patient Consent and Authorization Medicare

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment, administration of anesthetics and performance of diagnostic and or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to the physician(s) accepting the assignment of medical benefits applicable changes I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.
It is further agreed that any credit balance resulting from payment of insurance of other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

RELEASE OF INFORMATION

The physician(s) may disclose all of part of that patient's record to any person or corporation which is or may be liable to a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of companies, workers compensation carriers, welfare funds, or the patient's employer.

HMO DISCLAIMER

I certify that I am not presently enrolled in any health maintanence organization (H.M.O.) subsequent rejection or a claim in any H.M.O. plan will constitute responsibility for payment of claim by me on my behalf.

LIFETIME AUTHORIZATION:
MEDICARE AND MEDICAID PATIENT CERTIFICATION-PAYMENT
CLASSIFICATION
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under title and or title XIX or the social security act is correct: I authorize any holder or medical or other information about me to release to the social security administration or its intermediary carries, any information needed for this or a related Medicare, Mediciad, or other third party claim. I request that payment of authorized benefits be made on my behalf I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

SIGNATURE_____