

## AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payments within reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency which will leave you liable for additional expense incurred if applicable.

I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to the providers at Morgan Health Center. I also authorize the release of my information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the providers to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

I request that payment of authorized Medigap (Medicare supplement) benefits be made on my behalf to the provider for any services furnished me by that provider. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## MEDICARE LIFETIME AUTHORIZATION

HIC# \_\_\_\_\_

### Medicare Certification for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment for me.

I request that this authorization also apply to all other insurance.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title or Relationship: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Address: \_\_\_\_\_

If signed by other than beneficiary, state the reason the patient was unable to sign: \_\_\_\_\_

\_\_\_\_\_