Arthritis & Osteoporosis Clinic

Patient Authorization

Patient Name_____

Please initial all applicable boxes. If a category does not apply to you, please write "N/A".

Medicare Assignment of Benefits

Initials

_____ I certify that the information I have in applying for payment of Medicare benefits is correct. I assign Medicare benefits payable for A&O services to A&O, and I understand that I am responsible for any health insurance deductibles and co-insurance.

Financial Responsibility

_____ I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at A&O. I will honor A&O's payment policy. If I cannot pay in full at the time of service, A&O can ask others about my credit worthiness. I agree to pay all expenses related to collection, whether be collection agency or by an attorney.

Insurance Assignment

_____ I irrevocably assign and transfer to A&O all insurance benefits covering A&O's services including hospitalizations, health, and other insurance coverage for the payment of services rendered. I understand it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments and deductibles.

Authorization for Care

_____ I grant permission for A&O (including physician assistants and nurse practitioners) and associates to employ surgical, x-ray, and technical procedures, as they deem necessary in diagnosis and treatment of me.

Authorization for Release of Information

_____ I hereby authorize A&O to release necessary information for the following reasons: to other physicians for continuing professional care, to insurance company or third party payer for the purpose of processing a claim, or otherwise allowed by law. I release A&O from any liability for the release of this information, and I understand this release specifically includes any and all blood related test, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time. I also authorize A&O to receive my medication and other medical history via download or by any other means.

_____

Signature of Patient or Representative **Relationship to Patient** **Date**

_____

Witness **Date**

Updated 7-21-10