| E. Thomas Arne Jr., D.O., F.A.C.C.1250 S. Tamiami Trail Suite 401Sarasota, Florida 34239Office: 941-366-2194 Fax: 941-366-7025[www.gulfshorepc.com](http://www.gulfshorepc.com)  |  |  | IMG_4682 |
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**INSURANCE AUTHORIZATION AND ASSIGNMENT page 1 of 1**

I request that payment under the insurance program be either made to me or to the provider for any service furnished to me. I authorize the above-named provider to release any information needed for my medical claims to be paid. I further permit a copy of this authorization to be used in place of the original and I authorize the use of an electronic copy of the information. This signature will act as a lifetime authorization for Medicare.

I certify that the information I have provided in applying for payment under Title XVII of the Social Security Act is correct.

I authorize any holder of medical or other information about me, including hospitalization and or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or test for HIV, to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier of any information needed for the use of a Medicare related claim.

I request that payment of authorized benefits be made on my behalf and request payment of medical insurance benefits be made either to me or to the party who accepts assignment.

I authorize such physician or organization to submit to Medicare payment on my behalf. I understand that I am financially responsible for all charges whether or not paid by said health insurance.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_