

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named subscriber, hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID-Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration\Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

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

SUBSCRIBER (If different from patient): \_\_\_\_\_

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE  
MEDIGAP (SECONDARY INSURANCE) SIGNATURE

\_\_\_\_\_  
NAME OF BENEFICIARY                      HEALTH INSURANCE COMPANY                      MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on my behalf to SURGICAL GROUP OF GAINESVILLE, PA for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to SURGICAL GROUP OF GAINESVILLE, PA any information needed to determine benefits payable for related services

SUBSCRIBER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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