



## PATIENT CONSENT AND AUTHORIZATION

**CONSENT FOR TREATMENT:** I voluntarily consent to the rendering care of my child or myself, including treatments, administration of dilating eye drops, anesthetics and performance of diagnostic and/or surgical procedures.

**ASSIGNMENT OF BENEFITS:** I hereby assign payment directly to the physician accepting assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. 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 or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

**RELEASE OF INFORMATION:** The physician may disclose all or part of the patient's records to any person or corporation which is or may be liable under contract to the physician or to the patient or to a family member or employer of the patient for all or part of the physician's charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

**HMO DISCLAIMER:** I certify that I AM OR I AM NOT presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to current enrollment in a HMO plan will constitute responsibility for payment of claim on my part.

**COLLECTION POLICY:** I agree that should this account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney fees and court costs.

### LIFETIME AUTHORIZATION

#### MEDICAID PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

**REQUESTS:** I certify that the information given by me in applying for payment under Title XVIII and or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about my child or myself to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicaid 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature/ Person Responsible

Patient unable to sign do to: \_\_\_\_\_