Insurance Authorization, Assignment, and Consent of Treatment

ALL PAYMENTS, UNMET DEDIUCTABLES AND CO-PAYMENTS ARE DUE AT TIME OF REGISTRATION

Name of Beneficiary: _____ HIC Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Express Care of Ocala for any service(s) furnished by that provider. I authorize any holder of Medicare information about me to release to the Health Care Administrator and its agents any information needed to determine these benefits payable to related service(s).

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge and the patient is responsible only for the deductible, co-insurance, and non-covered service(s). Co-insurance and the deductible are based upon the charge determination of Medicare.

I understand all professional service(s) rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is ultimately responsible for all fees regardless of insurance coverage. All fees still pending with insurance companies after sixty days will be the responsibility of the patient.

I understand there will be a $25 fee for all accounts turned over to a collection agency and/or returned checks.

_____ _____

Signature Date

Reason for your visit: _____

Consent for Treatment

I certify that the above information is correct as of the date indicated. I hereby give Express Care of Ocala's medical providers permission to treat me or my ward. I understand that emergent and urgent care is provided, and no responsibility will be taken for long term patient care after normal office hours except in those cases under contract with Medipass where-in the patient is assigned to ECO as a primary care patient.

Date	Time	Signature
_____	_____	_____
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