



"The Best Surgeons in the Joint"

CONFIDENTIAL PATIENT INFORMATION

** PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARDS
SO THAT WE CAN MAKE A COPY FOR YOUR CHART**

MEDICARE CERTIFICATION AND/OR COMMERCIAL INSURANCE CERTIFICATION LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this doctor or supplier, any information needed for this or a related Medicare claim and/or my Private Health Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that this is a lifetime signature authorization. I request that this authorization to release medical information necessary to process my claims and pay the provider direct also apply to my private and/or group health insurance as applicable.

DATE: _____ **SIGNED:** _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for payment of this account, which includes all outstanding balances not covered by my insurance companies. I understand that payment is requested at the time services are rendered. I understand that a credit report may be obtained and reviewed if my account should exceed 60 days.

DATE: _____ **SIGNED:** _____

If signed by other than beneficiary, state title or relationship and the reason patient was unable to sign: _____
