PLEASE READ: ALL PAYMENTS, UNMET DEDUCTIBLES AND CO-PAYMENTS DUE AT TIME OF REGISTRATION.

INSURANCE AUTHORIZATION AND ASSIGNMENT AND CONSENT OF TREATMENT

Name of Beneficiary_____ HIC Number_____

I request that payment of authorized Medicare benefits and all other insurance benefits be made on my behalf to Above All Medical Clinic for any servicesfurnished me by that physician. I authorize any holder of medicare information about me to release to the Health Care Administration and it's agents any information needed to determine these benefits payable to related services.

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 HCFA-1500 claim form is completed, my signature authorizes releasing of the informationto the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge, andthe patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and thedeductible are based upon the charge determination of Medicare.

I understand all professional services 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 dollar fee for all accounts turned over to a collection agency and/or returned checks.

I understand I may receive a bill from an outside laboratory for any laboratory work done off premises. Above All Medical does not have any financial interest in any outside laboratories.

Signature_____ Date_____

Reason for your visit: _____

CONSENT FOR TREATMENT

I certify that the above information is correct on this date. I hereby give Above All Medical providers permission to treat me or my ward and permission to access my medication history from an external pharmacy. I understand that emergency or urgent care only is provided, and no responsibility will be taken for long term patient care after normal office hours.

DATE	TIME	SIGNATURE	DATE	TIME	SIGNATURE