PATIENT AUTHORIZATION FOR INSURANCE BENEFITS

Print Patient's Name: _____

Date of Birth: _____

Patients Medical Record Number: _____

INSURANCE INFORMATION

WE WILL NEED A COPY OF YOUR CURRENT INSURANCE CARD

I understand and agree that I will be responsible for the payment of all charges incurred on behalf of myself or family member.

X _____ _____

Signature of patient/guardian/responsible party Date

I authorize payment of Medical Benefits to DIABETES & ENDOCRINE ASSOCIATES OF THE TREASURE COAST or any physician of the practice

X_____ _____

Signature of patient/guardian/responsible party Date

MEDICARE: I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT FOR PAYMENT ON MY BEHALF TO DIABETES & ENDOCRINE ASSOCIATES AND ITS PHYSICIANS UNDER TITLE XVIII, OF THE SOCIAL SECURITY ACT.

X_____ _____

Signature of patient/guardian/responsible party Date

**** IF YOUR INSURANCE REQUIRES AN AUTHORIZATION FOR YOU TO SEE THE DOCTOR, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE AUTHORIZATION. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO AUTHORIZATION – YOU THE PATIENT AGREE TO PAY DIABETES & ENDOCRINE ASSOCIATES AND ITS PHYSICIANS, IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

X_____ _____

Signature of patient/guardian/responsible party Date

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE OF DIABETES & ENDOCRINE ASSOCIATES TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO DIABETES & ENDOCRINE ASSOCIATES OR ANY PHYSICIAN OF THE PRACTICE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

X_____ _____

Signature of patient/guardian/responsible party Date