Physicians at Sweetwater

PHYSICIANS AT SWEETWATER - *PEDIATRICS*

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage applicable to _____ (name of child) with _____ and assign directly to Physicians at Sweetwater all medical benefits, if any, otherwise payable to me for services rendered. I authorize Physicians at Sweetwater to furnish information to insurance carriers concerning the illness of named person. *This information will include treatment records, medication records, laboratory reports, history and physical and information on communicable diseases and will be used for insurance payment purposes. This authorization is valid until I revoke it. I have the right to refuse this release of information. If I refuse to release this information, I understand that I am financially responsible for all charges and must pay for services at the time of delivery.* I further understand that I have financial responsibility for all services whether or not paid by insurance. I hereby authorize the use of my signature on all insurance submissions.

X_____ Yes ( ) No ( )

Signature of Parent/Guardian/Guarantor Date Check Agreement to Release Information

MEDICAID AUTHORIZATION/ATTESTATION

I request that payment of authorized Medicaid benefits be made on behalf of _____ (name of patient) to Physicians at Sweetwater for any services furnished to named patient by physicians of this Group. I authorize any holder of medical information applicable to patient to release this information to Medicaid and its agents needed to determine benefits. *Such release may include treatment records, medication records, laboratory reports, history and physical and information on communicable diseases. This authorization is valid until I revoke it. I have the right to refuse this release of information. If I refuse to release the information, I understand that I cannot be provided benefits under Medicaid.* My signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I attest that this patient is eligible for Medicaid coverage.

X_____ Yes ( ) No ( )

Signature of Parent/Guardian/Guarantor Date Check Agreement to Release Information

TREATMENT AUTHORIZATION

I authorize Physicians at Sweetwater to give _____ (name of patient) reasonable and proper medical care by today's standards

X_____

Signature of Parent/Guardian/Guarantor Date

LAB INSURANCE CONSENT

I authorize and give Physicians at Sweetwater my consent to submit specimens (blood, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include submission for payment to the insurance carrier for this patient and/or to me for charges incurred and agree to full responsibility and payment for any non-covered medical services. *I authorize release of any clinical information including treatment records, medication records, laboratory reports, history and physical and information on communicable diseases as may be necessary for laboratory to submit information to the insurance carrier, including Medicaid. This authorization is valid until I revoke it. I have the right to refuse this release of information. If I refuse to release the information, I understand that I cannot be provided benefits under Medicaid and commercial insurance and the laboratory will require payment for services at the time of service.* My signature requests that payment be made to the authorized laboratory and authorizes release of medical information necessary to pay the claim.

X_____ Yes ( ) No ( )

Signature of Parent/Guardian/Guarantor Date Check Agreement to Release Information

RESPONSIBLE PARTY AGREEMENT

I, _____ guarantor of this account, agree to pay the balance due. Should the collections department need to contact me regarding this account and are unable to reach me by mail or home phone, then I may be reached at my work phone.

X_____

Signature of Parent/Guardian/Guarantor Date

Note: Words in *italics* indicate those required for HIPAA compliance as of 12/30/02