



Authorization of Care/Release of Information And Assignment of Benefits

CONSENT TO TREAT

The term "Healthcare provider(s) in this document means St. Francis Medical Group / Oncology & Hematology Specialists its agents and employees, members of the medical staff, their agents and employees, and other healthcare practitioners who provide care to patients. Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

RELEASE OF INFORMATION

Information about me necessary to substantiate any insurance claims may be released by the healthcare provider involved in my care.

AUTHORIZATION TO APPEAL

I authorize IOHC to initiate an appeal for denied or underpaid services with my insurance company on my behalf.

FINANCIAL RESPONSIBILITY/HMO MEMBERS

I authorize any HMO insurance plan in which I am enrolled to pay benefits directly to my HMO Healthcare Provider. I agree to pay all relevant copays for services covered by my HMO plan. Payment for services not covered by my HMO benefits will be my responsibility. If copays and payment for non-covered services are not paid appropriately, collection of the amount due shall be as described under Financial Responsibility/Assignment of Benefits. Co-Payments are due at the time of service. I authorize SFHHS and its agents & employees to file an appeal on my behalf with my insurance company for denied or underpaid services.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those healthcare providers who have rendered services to me and who accept such assignment.

I agree to pay all charges, which are not paid in full by assigned insurance. If amounts due to the healthcare providers are not paid after reasonable notice, the account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to «Practice» for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the 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 other health insurance is indicated on item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Printed Name

Signature

Relationship (If other than patient)

Date

Witness

Date

Witness

Date