



Patient Name _____

Authorization to Release Information and Pay Benefits

I hereby authorize Hendricks Regional Health Medical Group to furnish information to my insurance carrier(s) concerning my illness, treatments and diagnosis, upon written request.

I further authorize my insurance company to pay directly to the doctor all payments for medical services rendered to my dependents or myself. I understand that I am financially responsible for any charges not paid by my insurance carrier and that this authorization will remain in effect until all charges are paid in full.

Consent to Treat

I, the undersigned, as the patient or his/her authorized representative, hereby consent to treatment by the physicians and staff of the Hendricks Regional Health Medical Group. I further authorize such medical services on any subsequent visits. I have the right to revoke this consent at any time by communicating such decision in writing.

Office Policies Received (Please Initial) _____

I have been offered the Notice of Privacy Practices (Please Initial) _____

Signature

Date

Medicare Patients: Please sign additional consent

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Hendricks Regional Health Medical Group providers for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for 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 in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

Patient Signature _____ Date _____