Authorization Regarding Payment and Release of Medical Information

Patient’s Name: ___________________________________  Chart #: __________________

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to University Specialty Clinics - Surgery. I hereby assign to University Specialty Clinics - Surgery all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payers.

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

___________________________________  __________________________________
Patient’s/Patient’s Representative’s Signature  Witness Signature

__________________  __________________
Date  Date

Printed Patient’s or Representative’s Name

Representative’s Relationship to Patient

Consent to Treatment

I hereby agree to and give consent to the physicians, healthcare providers, associates, consultants and residents of University Specialty Clinics - Surgery to diagnose and treat me. I consent to any and all treatment including, but not limited to, physical examinations, psychological examinations, x-rays, laboratory procedures, and other procedures related to routine diagnosis and treatment as determined appropriate by the practice’s physicians, healthcare providers, associates, consultants and residents.

___________________________________  __________________________________
Patient’s/Patient’s Representative’s Signature  Witness Signature

__________________  __________________
Date  Date

Printed Patient’s/Representative’s Name

Representative’s Relationship to Patient