GENESIS FAMILY HEALTH CENTER, PLC

PATIENT SIGNATURE AUTHORIZATION **

Patient Name: ____ D.O.B. ______________
(Last) (First) (Middle)

GENERAL SIGNATURE

I understand that I am responsible for payment of services that are rendered to me. I understand that Genesis Family Health Center, PLC will bill my insurance but that I am ultimately responsible for any balance not covered by my insurance, i.e. co-payments, deductibles, or non-covered services.

SIGNATURE: ____ Date: ________________
PATIENT, PARENT OR GAURDIAN, IF PATIENT IS A MINOR

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE

Do you receive payment from carrier when a medical claim is filed and then **you pay** the provider? Y N

I, the undersigned authorize payment of medical benefits to Genesis Family Health Center, PLC for any services furnished to me by Genesis Family Health Center, PLC. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent(s) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signature: ____ Date: ________________
PATIENT, PARENT OR GAURDIAN, IF PATIENT IS A MINOR

VERIFICATION OF NON-INJURY

I, the undersigned, agree that my illness or injury is not related to a Worker's Compensation, Automobile or other accident/injury claim in which a carrier other than my health insurance should be billed.

Signature: ____ Date: ________________
PATIENT, PARENT OR GAURDIAN, IF PATIENT IS A MINOR

MEDICARE PATIENTS ONLY

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Genesis Family Health Center, PLC for any services furnished to me by Genesis Family Health Center, PLC. I authorize any holder of medical information about me to release the information to the Centers for Medicare and Medicaid Services (CMS) and it's agents in order to determine payable benefits for services rendered.

Signature: ____ Date: ________________

Medicare Policy Number: ______________________________

MEDIGAP SIGNATURE ON FILE

(To be completed if you have secondary insurance in addition to Medicare)

Do you receive payment from the carrier when medical claim is filed and then **you pay** provider? Y N

I request that payment of authorized Medigap benefits be made on my behalf to Genesis Family Health Center, PLC. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services (CMS), it's agents and my Medigap or other insurance policy that I have, and any information needed to determine these benefits or the benefits payable for related services.

Signature: ____ Date: ________________

Medigap Carrier Name: ______________________________ Medigap Policy Number: ________________