

Name:
DOB:
Age:
Chart:

Date:

PATIENT'S NAME

FIRST

MIDDLE

LAST

BIRTHDATE

MEDICARE AUTHORIZATION

I CERTIFY THAT INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE 18 OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE CLAIMS. I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE IN MY BEHALF. I UNDERSTAND I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLES AND CO-INSURANCE.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL

I HEREBY AUTHORIZE ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS (AS LISTED BELOW) CONCERNING THIS ILLNESS/ACCIDENT, AND I HEREBY IRREVOCABLY ASSIGN TO THE DOCTOR / CORPORATION ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

INSURANCE COMPANY

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

INSURANCE COMPANY

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND MEDICATION HISTORY REQUESTS

NOTICE TO PATIENT:

WE ARE REQUIRED TO PROVIDE YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH STATES HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION. PLEASE SIGN THIS FORM TO ACKNOWLEDGE RECEIPT OF THIS NOTICE. YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT, IF YOU WISH

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

I AGREE THAT ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C. MAY REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS OR THIRD-PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES.

SIGNATURE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FRIEND AND/OR FAMILY MEMBERS

I, _____ AUTHORIZE THE PHYSICIANS AND/OR STAFF OF ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C. TO RELEASE INFORMATION CONCERNING MY ILLNESS/ACCIDENT TO THE PERSONS LISTED BELOW:
NAME AND RELATIONSHIP OF PERSON. _____

I UNDERSTAND THAT THIS AUTHORIZATION WILL BE EFFECTIVE UNTIL, AT ANY TIME, I REVOKE THIS AUTHORIZATION IN WRITING; EXCEPT TO THE EXTENT THAT ACTION WAS ALREADY TAKEN ON THIS SIGNED AUTHORIZATION.

SIGNATURE

WITNESSED BY

DATE

FOR OFFICE USE ONLY

WE HAVE MADE EVERY EFFORT TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES FROM THIS PATIENT BUT IT COULD NOT BE OBTAINED BECAUSE:

- THE PATIENT REFUSED TO SIGN.
- DUE TO AN EMERGENCY SITUATION IT WAS NOT POSSIBLE TO OBTAIN AN ACKNOWLEDGEMENT
- WE WEREN'T ABLE TO COMMUNICATE WITH THE PATIENT
- OTHER (PLEASE PROVIDE SPECIFIC DETAILS)

EMPLOYEE SIGNATURE

DATE