AUTHORIZATIONS

ALL PATIENTS

I Authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers to my attorney or another physician's office. I, hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, Private insurance, and any other health plan to Holy Redeemer Physician Services and any of its affiliated practices.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that, as these services were preformed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of patient or responsible party Date

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Holy Redeemer Physician Services and any of its affiliated practices for any services furnished to me by Holy Redeemer Physician Services and any of its affiliated practices. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

_____ _____

Medicare Beneficiary Signature Date

Medicare Number_____

Do you or your spouse work for a company that provides you with health insurance?

___Yes ___No

Are you entitled to Medicare because of disability or End Stage Renal Disease?

___Yes ___No

Is the illness or injury the result of an automobile accident or other injury?

___Yes ___No

Has treatment for the accident or illness been authorized by the Veteran Administration?

___Yes ___No

Are you entitled to any benefits under the Federal Black Lung Program?

___Yes ___No

I certify that this information is true and complete to the best of my knowledge

_____ _____

Signature Date