

Account #: _____

Financial Policy and Release Form

Patient Name: _____

Lakeside ENT & Allergy, LLC Financial Policy

Please read and sign the attestation below.

By my signature below I certify I have received a copy of the Lakeside ENT & Allergy, LLC Financial Policy. I understand that it is my responsibility to familiarize myself with these policies. I also understand that due to the changing nature of the healthcare industry it may be necessary to update these policies and that Lakeside shall be willing to provide an up-to-date copy of the policies upon my request.



Signature

Date

Uniform Assignment and Release of Information Statements

I hereby authorize release of information in relation to medical treatment by Lakeside ENT & Allergy, LLC to the insurance carriers, or others who are financially liable for my medical care all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.



Signature

Date

I hereby assign to Lakeside ENT & Allergy, LLC sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or to others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.



Signature

Date

Medicare Benefits Lifetime Authorization

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this on my behalf to the physician or organization furnishing the services provided to me. I authorize any holder of medical information about me to release to the MEDICAP insurer any information needed to determine these benefits or the benefits payable for related services. I request that payment under the medical insurance program be made either to me or to any physician for services provided to me.



Signature

Date