General Internal Medicine Group, P.C.

Insurance Claims filing and Information Release Authorization

PLEASE GIVE THE RECEPTIONIST YOUR CURRENT MEDICAL INSURANCE CARD (S) SO WE MAY KEEP A COPY ON FILE.

Patient Name:_____**Date of Birth**_____
Social Security Number:_____**(for identification purposes)**

I authorize General Internal Medicine Group, P.C. to file claims to my insurance company (s) for services rendered to me by General Internal Medicine Group, P.C. I certify that the information I have reported with regard to my insurance company is correct. I understand that I am responsible to notify General Internal Medicine Group if my insurance company changes, benefits are terminated or if the coverage I have reported is incorrect. I understand and agree that it is my responsibility to understand the benefits of my insurance plan and that failing to do so may result in lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payment in full for all services that I have received from General Internal Medicine Group. I understand and agree that any and all referral, documentation and/or information, if required, are MY responsibility to obtain and provide to General Internal Medicine Group, P.C.

I authorize General Internal Medicine Group, P.C. to release any information, including medical information for claims to my insurance company(s) or reimbursing agency, or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration, in order to determine benefits to which I may be entitled. I hereby authorize payment be made directly to General Internal Medicine Group, P.C., realizing that I am responsible to pay any deductible, copay or non covered service as determined by my insurance company. In the event the account must be placed with an attorney or collection agency to obtain payment from me, I shall be responsible for all attorney and collection fees incurred.

I may revoke this authorization at any time in writing. In the case of Medicare Coverage, the Social Security Administration may revoke this authorization at any time in writing.

I have read, understand and agree to the terms and conditions above.

_____ _____
Signature of Responsible Party Date

_____ _____
Witness Date

If the patient is under the age of 18, please complete the following:
The undersigned is a parent/guardian of the patient and executed this form on behalf of the patient.
Name:_____Relationship to patient:_____

_____ _____
Signature Date

FOR PATIENTS WHO DO NOT HAVE THEIR INSURANCE CARD AND/OR A REFERRAL IF REQUIRED

I acknowledge that I did not bring a referral as required by my insurance company and/OR do not have my insurance card. I am electing to be seen today and agree to pay for the services rendered since I do not have a valid referral or insurance card.

_____ _____
Signature **Date**