

# SALEEBY AND WESSELS PROCTOLOGY PAYMENT AUTHORIZATION FORM

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please read this payment authorization form carefully. Sign the appropriate assignment of benefits which pertains to you. If you have **both** private insurance and Medicare you should sign **both**.

## For Patients with Insurance

If you have health insurance other than Medicare or Medicaid please read and sign this assignment of insurance benefits:

I authorize this office to release any medical information related to my treatment including office visits, hospital care and outpatient procedures to any insurance company responsible for paying benefits pertaining to health services rendered to me. I further assign all medical and or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to this office for payment. This will remain in effect until revoked by me in writing. I understand that this assignment does not relieve me of my financial responsibility for all professional fees and charges incurred by me or anyone on my behalf and I accept all such responsibility. I am financially responsible for all charges whether or not paid by said insurance as well as costs associated with collection efforts including but not limited to collection agencies, legal and attorney fees. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guarantor if different from above and Relationship to Patient

\_\_\_\_\_  
Date

## For Patients with Medicare or Medicaid

If you have Medicare or Medicaid please read and sign this assignment of insurance benefits:

I request payment of authorized Medicare and/or Medicaid benefits be made on my behalf to this office for any services provided. I assign the benefits payable for physician services to this office and authorize the office to submit a claim on to Medicare and/or Medicaid on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or appropriate North Carolina agencies any information needed to determine these benefits or the benefits payable to related services. This release applies to other insurers listed on approved claim forms as well. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and any non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guarantor if different from above and Relationship to Patient

\_\_\_\_\_  
Date