Authorization for Insurance Payment-JRWC Policy

It is a courtesy for our office to file insurance claims though the patient/guardian is still responsible for all charges incurred if payment by insurance is denied. You will still be responsible for any co-pay and/or percentage, for which the insurance carrier is not liable at the time services are rendered. In the event that your insurance carrier has not remitted payment to us within 45 days of the date of claim receipt, the entire account balance becomes the patient/guardian's responsibility.
It is solely the patient's responsibility to obtain prior to their appointment any referrals required of them by their insurance carrier or you will be liable on the date of services for all charges incurred. If we are unable to obtain satisfactory payment from the patient within a reasonable amount of time, your account will be placed with a collection agency for aggressive collection action. At that time, you will be held liable not only for the account balance but also for any costs associated with the collection agency's involvement.

I, _____, do hereby authorize the physicians at JRWC to administer treatment as they deem advisable for my diagnosis and/or treatment. I certify that I have been made aware of the role and services offered by the physicians, nurse practitioner, and nurses at JRWC and consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____
Patient/Guardian Signature Date

_____
Witness

Medical/Medigap Lifetime Authorization

HIC # _____ (Medicare ID number) ***ONLY Medicare Patients Sign***

*I certify that the information given to me in applying for payment under Title XVII of the Social Security Administrative Act is correct. I hereby authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers of any information deemed necessary for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf; I assign the benefits payable for physician services to the physician or organization furnishing the services.

_____ _____
Patient/Guardian Signature Date

_____ _____
Printed Name Relationship to Patient

_____ _____
Witnessed By Address

Reason Patient is unable to sign:
_____