

PATIENT CONFIDENTIALITY

I hereby authorize the release of medical information to _____ relationship _____

I hereby authorize Johnson County Spine to leave information on my voice mail at (circle): HOME OFFICE CELL PHONE

PATIENT SIGNATURE: _____ DATE: _____

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM OR BOTH PAGES IF FILLING OUT ONLINE

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made to Johnson County Spine. I understand that I am financially responsible for all of the charges whether or not they are covered by insurance. In the event of default, I agree to pay all the cost of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits; and agree that a photocopy of this agreement shall be as valid as original.

PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZATION AGREEMENT

I authorize the release of my medical records as needed to any physician, facility or other provider of services that Johnson County Spine asks to participate in my medical treatment.

PATIENT SIGNATURE: _____ DATE: _____

MEDIGAP AUTHORIZATION

I hereby authorize payment of my Medigap benefits to Johnson County Spine for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

BENEFICIARY SIGNATURE: _____ DATE: _____

MEDICARE NUMBER: _____

MEDIGAP INSURER: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

IF THIS IS A WORK COMP OR AUTO ACCIDENT THE FOLLOWING INFORMATION MUST BE PROVIDED

CONTACT NAME: _____

PHONE NUMBER: _____ YOUR CLAIM NUMBER: _____

INSURANCE COMPANY NAME: _____

ADDRESS: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE COMPANY CONTACT NAME: _____