

Grayson Primary Care
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(678) 225-4999 – Fax (678) 225-5546

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature **Date**

Witness

I request that payment of authorized Medigap (Medicare supplement) benefits be made on my behalf to the provider for any services furnished me by that provider. I authorize any holder of medical information about me; to release to Medigap Insurer _____ any information needed to determine these benefits payable for related services.

Signature **Date**

MEDICARE LIFETIME AUTHORIZATION

HIC# _____

Medicare Certification for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed 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 or authorized such physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance.

Signed: _____ **Date:** _____

Print Name: _____ **Title or Relationship:** _____

Witnessed by: _____ **Address:** _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____
