# INSURANCE

Name: _____

Date of Birth: _____

Primary Insurance: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

**MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Jack E. Padour, MD for any services provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine benefits payable for these or related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under the Title XVII of the Social Security Act.

**COMMERCIAL INSURANCE**: I hereby authorize payment of benefits directly to the attending physician. I understand I am financially responsible for the charges not covered by insurance payments. I hereby authorize the attending physician to release any information acquired in the course of my examination and treatment to permit processing of claims for insurance reimbursement.

Although an insurance claim is filed, the patient is ultimately responsible for payment of the account.

A photocopy of this signature is valid as the original.

PRINT PATIENT NAME: _____

SIGNATURE: _____ DATE: _____