

Account# _____

Authorization to Pay Benefits to Physician

Private Insurance Authorization for Assignment of Benefits and Information Release:

I, undersigned, authorize payment of medical benefits to Spartanburg & Pelham OB-GYN, P.A., for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance.

Date: _____ Signed: _____
Insured or Responsible Party

Medicare Patients Only:

I request the payment of authorized Medicare benefits be made on my behalf to Spartanburg & Pelham OB-GYN, P.A., for any services furnished me by the physician. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents, by mail or fax; any information needed to determine these benefits or benefits payable for related services.

Date: _____ Signed: _____
Insured or Responsible Party

Medical Records Release

Medical Records Release:

I authorize you to release to my insurance company and my consulting physician, by mail, fax or secure internet, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for treatment, payment and operations. Refer to privacy notice.

Date: _____ Signed: _____

Parent or legal guardian signature: _____
Required for minors through age 17

Relationship to patient: _____

Medical Services Authorization:

Medical Services Authorization:

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a copy of the Privacy Policies and Practices of Spartanburg & Pelham OB-GYN, P.A., which provides a more complete description of information uses and disclosures.

Date Signature of Patient or Legal Representative Witness

I request the following restrictions to the use or disclosure of my health information. _____

Telephone / Email Message Release

Patient _____ Date _____

The staff and doctors of Spartanburg & Pelham OB- GYN, P.A., have my permission to leave all necessary messages regarding the patient listed above on voice mail, answering machine or by email through a secure site. **This would only authorize us to remind you of an appointment or to have you call us back. No detailed medical information will be given.**

Patient

Parent or Legal Guardian (for minors through age 17)