In case of Emergency, Contact: _____ Relationship: _____

Home Phone: ( )_____ Work Phone: ( )_____ Other: ( ) _____

Please read, sign, and date the following to allow us to bill your insurance company for your medical care:

I have completed this form and certify that I am the Patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by Capital Health required to substantiate or explain insurance claims filed, and I authorize payment directly to Capital Health and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Capital Health for any services furnished to me by that physician or supplier. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Capital Health Primary Care - Quakerbridge for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to

_____

(Name of Medigap Insurer)

any information needed to determine these benefits payable for related services.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE

****

I have read and reviewed the attached, and there are no changes to the information provided.

(To be re-signed once a year)

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____