1200 East Davis St. Suit 113
Mesquite, TX 75149

Phone # (972) 295- 9090
Fax # (972) 534-0010

AUTHORITZATION FORM

Patient Name: ______________________

Medicare Assignment of Benefits to <u>Statement to Permit of Health and/or Medical Insurance Benefits to</u>

<u>Pioneer Healthcare Clinic and Providers</u>

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician and/or midlevel (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and coinsurance.

FINANCIAL RESONSIBILITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, in the I am unable to pay in full at the time service in rendered, Pioneer Healthcare Clinic may inquiry of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5%)per month/18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to ad attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expense.

INSURANCE ASSIGNENT

In consideration of services rendered or to be rendered , I hereby irrevocably assign and transfer to Pioneer Healthcare Clinic, Mesquite, Texas any benefits payable to or for my benefits under hospitalization, sickness, liability, compensation, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate , aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of al policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

AUTHORIZATION FOR CARE

I hereby authorize staff of Pioneer Healthcare Clinic to administer such care/treatment as is necessary based on the clinical providers assessment and diagnosis. I understand that such care may include medical and surgical treatment , and laboratory, and radiologic test. I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize Pioneer Healthcare Clinic to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein; to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer(or their agent/s) for the purpose of obtaining payment to employees, officers and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this released specifically includes any and all blood and related tests including test results reflecting presence of HIX, HBV, and other diseases, all of which I specifically authorize to be so released.

______________________________	__________________	________
Signature of Patient or Representative	Relationship to patient	Date
________________________	__________________	________
Responsible Party(If different)	Relationship to patient	Date