AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN

I hereby consent to treatment by Mid-Atlantic Family Medicine physicians, their associates, and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include injections and/or such other procedures deemed necessary.

I understand that payment (or co-payment) is expected at the time of service, and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not paid by this authorization. Should collection actions become necessary, I understand that I will be liable for all costs, including reasonable attorney fees associated in collecting the unpaid balance owing on my account.

I hereby authorize the release of any information necessary for filing of any insurance and direct payment to Mid-Atlantic Family Medicine physicians for any amounts due under my present policy/policies or any policy that I may have at a later date ask to be filed. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise Mid-Atlantic Family Medicine of any changes in insurance coverage.

I also authorize Mid-Atlantic Family Medicine to talk with and exchange information with other medical professionals regarding my medical condition. If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through the exposure, including HIV/AIDS and hepatitis.

Signed: _____ _____ _____

Patient or Responsible Party Date Witness

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mid-Atlantic Family Medicine for any services furnished me by Mid-Atlantic Family Medicine. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ _____ _____

Patient or Responsible Party Date Witness