consensushealth™

Account #:

Assignment of Benefits / Authorization / Notice of Collection Action

I understand that I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (e.g. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Consensus Health Medical Group Payment Policy and Notice of Privacy Practices for more information.)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Vaccine Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to your State Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record or patient's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

Patient Name **(Please Print)** _____ Patient Signature _____

Guarantor/Parent/Guardian completing this form **(Please Print)** _____ Date _____

Guarantor/Parent/Guardian Signature _____ Date _____

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Patient Name **(Please Print)** _____ Patient Signature _____

Guarantor/Parent/Guardian completing this form **(Please Print)** _____ Date _____

Guarantor/Parent/Guardian Signature _____ Date _____