

# MARYLAND PODIATRY CENTER

## Assignment of Benefits & Authorization to Release Information to My Insurance Company

I, the undersigned certify that I (or my dependent) have insurance coverage with the above plan(s), and hereby assign all insurance benefits, if any, otherwise payable to me, directly to John Murphy DPM for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(s).

I authorize the use of my signature below to reflect my agreement and authorize for the above for all insurance submissions.

**Responsible Party Signature** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

### Medicare Authorization

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to John Murphy, DPM for services rendered. I hereby authorize the doctor to release to the Centers of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Section 9 of the HCFA 1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-payment, and charges associated with non-covered services. Co-payments and deductibles are based upon the charge determination of the Medicare carrier.

**Beneficiary Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPPA educational pamphlet provides information about how John Murphy, DPM, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996(HIPPA).

We reserve the right to change the items described. Should this happen, you will receive a revised copy. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you. By signing below, you acknowledge receipt of our HIPPA regulations.

**Patient or Legal Guardian Signature** \_\_\_\_\_

### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Effective Date: April 14, 2003)

(\*\*NOTE: You have the right to refuse to sign this Form)

For professional Use Only

No signature above is for the following reason:

\_\_\_ Individual refused to sign

\_\_\_ Communication barrier prohibited obtaining a signed acknowledgment

\_\_\_ Emergency services prohibited obtaining a signed acknowledgment

\_\_\_ Specify other reasons \_\_\_\_\_

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