Print Form Clear Form

LOURDES	Insurance Information and Assignment of Benefits	John W. Miller, M.D. James R. Steinmetz, M.D. Peter E. Lethin, M.D. Jennifer MaLossi, M.D.

Patient Name: _____ **DOB:** _____

Responsible Party Name: _____
(if different from above)

Address: _____

_____

Telephone: Home: _____ **Cell:** _____ **Work:** _____

Patient SS#: _____ **Referring Physician:** _____

INSURANCE INFORMATION

Primary Insurance: _____

Insured Name: _____ **Relationship:** _____
(e.g.: Self, Spouse, Parent)

Policy Number: _____ **SS#:** _____

Group Number: _____ **DOB:** _____

Secondary Insurance: _____

Insured Name: _____ **Relationship:** _____
(e.g.: Self, Spouse, Parent)

Policy Number: _____ **SS#:** _____

Group Number: _____ **DOB:** _____

ASSIGNMENT AND RELEASE:

I, hereby, authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance; this includes but is not limited to copays, deductibles, or non-covered services. If this account becomes delinquent and is placed with a collection agency I am responsible for all fees. I authorize the physician to release any information necessary to process a claim. I also authorize the physician to release any medical records to my primary M.D., referring M.D. or other healthcare professional deemed necessary for my ongoing medical care.

Signature: _____ **Date:** _____
(Patient or guardian, if patient is a minor.)

MEDICARE PATIENTS -- MEDICARE CERTIFICATION:

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 information about me to release to the Social Security Administration, or it's carriers, any information required to process my Medicare claims.
I request the payment under the medical insurance program be to Broome Urological Associates for services provided to me during my entire life time.

Signature: _____