Patient Authorization

Patient Name: _____

Please initial all applicable spaces, to the right. Write N/A if the item does not apply to you.

Patient will be referred to as "I", "me", and "my" and ETIDC means East Texas Infectious Disease Consultants, its affiliates entities and its employees. My signature on this agreement is my request to obtain services.

Authorization for Care

I give my permission for ETIDC to render such are and/or treatment that my physician may deem necessary for my diagnosis and/or situation. I understand that such care may include basic medical treatment and minor office surgical procedures including IV therapy. _____

Authorization for Release of Information

I do authorize ETIDC to release information for the following reasons: to other physicians for continuity of

care, to any insurance company or third party payer for payment of a claim, or otherwise as allowed by law. I release ETIDC from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization can be revoked and is limited in time. _____

Insurance Assignment of Benefits

I irrevocably assign and transfer to ETIDC all insurance benefits covering services provided, including hospi-

talization, health, liability, works' compensation and any other insurance coverage. I understand that it is my responsibility to comply with all precertification requirements and that I am responsible for any co-payments and deductibles. _____

Medicare Assignment of Benefits

I certify that the information I gave in applying for payment of Medicare benefits is correct. I do hereby assign Medicare benefits payable for services rendered to ETIDC and I understand that I am responsible for any health insurance deductibles and co-insurance required. _____

Financial Responsibility

I understand that insurance coverage is not always guaranteed and therefor I agree that I am ultimately responsible for payment of services rendered by ETIDC. I will honor ETIDC's payment policies. If I cannot pay in full at the time of service, ETIDC can check into my credit worthiness. I agree to pay all expenses related to collection, whether by an agency or an attorney. _____

_____	_____	_____
Signature	Relationship to Patient	Date

_____	_____
Witness	Date

Submit