

Patient Name: _____

Date of Birth: _____

Insurance Information Release Consent Form

MEDICARE AUTHORIZATION

Initials Date

I authorize the holder of medical or other information to release to the Social Security Administration and Health Care Financing Administration, its intermediaries or carrier, any information needed to file a Medicare claim. I permit a copy of this authorization form to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. DEDUCTIBLE AND CO-INSURANCE (20% IF NO SUPPLEMENT) IS DUE AND EXPECTED AT THE TIME OF SERVICE.

TRICARE INSURANCE

Initials Date

If you have Tricare or Tricare Prime, please READ CAREFULLY:

We are currently certified providers with Tricare and in Network with Tricare Prime; however, Tricare Prime (Active Duty members) does require a referral and/or prior authorization for which the patient is responsible for acquiring from their primary care physician.

I authorize the release of medical information for services rendered to my insurance company, and also authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance. I also consent to the taking of photographs for medical, teaching purposes and office use.

Signature: _____ Date: _____