

**Insurance Authorization, Assignment and Guarantee of Payment**

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Suncoast Family Medical Associates for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information).

I request that payment under the Medicare or other medical insurance program(s) be made to Suncoast Family Medical Associates for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by Suncoast Family Medical Associates from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Suncoast Family Medical Associates for services rendered.

I understand that I am responsible for payment of all charges and fees to Suncoast Family Medical Associates that they are entitled to collect that are not paid for by Medicare or other insurance.

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Diagnostic and/or Therapeutic Procedures**

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunizations(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_