Raymond M. Thomas, MD PC

Insurance Authorization / HIPAA Acknowledgement

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS
I hereby authorize release to insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment and to permit representative thereof to examine and make copies of all necessary records.

- ❑ Accept
- ❑ Reject

I hereby assign to **Raymond M. Thomas, MD** sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers, or to others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

- ❑ Accept
- ❑ Reject

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I hereby acknowledge that I have been provided a copy of, or been offered the opportunity to receive a copy of the **Raymond M. Thomas, MD PC Notice of Privacy Practices.**

- ❑ Accept
- ❑ Reject

LIFETIME AUTHORIZATION FOR PATIENTS ENTITLED TO MEDICARE BENEFITS
I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims. I further permit a copy of this authorization to be used in place of the original.

- ❑ Accept
- ❑ Reject

I AGREE TO BE RESPONSIBLE FOR ANY UNPAID BALANCE ON MY ACCOUNT, EVEN IF I HAVE MEDICAID.

- ❑ Accept
- ❑ Reject

FOR ALL ACCEPTED ABOVE:

Signature of patient_____ OR representative _____

Print Name _____ Date of Birth _____

Date _____

Authorization period: Today's date until revoked.