MEDICARE PATIENT'S CERTIFICATION (If Applicable):

I certify that the information given by me in applying for payment under Title X VII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the release of any medical information necessary to process this claim. I further authorize the Clinic to release to the insurers herein specified or to any agency concerned with the payment of my Clinic charges any and all information (including copies of records) relating to this visit. I also authorize release of medical treatment to any accrediting agents for legal or regulatory surveying.

ASSIGNMENT OF INSURANCE BENEFITS/DISTRIBUTION OF OVERPAYMENT & OBLIGATION OF GUARANTOR:

Each of the undersigned hereby authorizes all of (his/her) insurers, whether or not specified, to make payments of the insurance benefits directly to the Clinic rather than to said undersigned. The undersigned patient recognizes, however, that (he/she) remains financially responsible to the Clinic for charges not paid or covered by said insurers. Each of the undersigned insured's also hereby authorizes any overpayment to the Clinic regarding this visit which would otherwise be payable to said undersigned to be applied and credited against any previous balance due the Clinic for which said undersigned is the responsible party. I also irrevocably assign to the Clinic all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover. I, the undersigned guarantor, hereby guarantee full and prompt payment to the Clinic of all charges made as a result of services rendered to the below named patient. I agree to pay the Clinic for said charges upon the failure of said patient, any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal or court required in the collection of any unpaid accounts.

PATIENT/INSURED/GUARANTOR	**DATE**	**BY**	**RELATIONSHIP**
INSURED/GUARANTOR	**DATE**	**WITNESS**	**DAT**

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Chart Copy

AUTHORIZATION TO RELEASE INFORMATION

Brazosport Regional
FAMILY MEDICINE CENTER

Patient Name:_____ DOB: _____