

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request the payment of authorized Medicare benefits be made on my behalf to HealthQuest, PC for any services furnished to me. I authorize any holder of medical information about me to be released to the Healthcare Finance Administration and its agents for any needed information to determine these benefits and for the benefit payable for related services. I authorize HealthQuest PC to send such information. I, further, authorize HealthQuest, PC to send any psychotherapy notes that may be requested by Medicare and its agents. This release shall be in effect for the entirety of my treatment at HealthQuest. I agree to pay for services rendered that are not covered by Medicare such as missed appointments, telephone consults, completion of disability forms, legal dispositions, non-routine medication refills calls as outlined in the practice policy, and any other forms that are non-routine. I also agree that I will pay for any lab work required that is not covered by Medicare. By signing this agreement, I also agree to pay any coinsurances or deductibles Medicare states I owe.

Patient/responsible party

Date

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I authorize HealthQuest, PC or any person designated by them, to obtain/release copies of my medical records to any PHYSICIAN or INSTITUTION for the purpose of evaluation and/or treatment, which also includes any pharmacy assisting in refilling medications.

Patient/responsible party

Date

AUTHORIZATION TO PAY BENEFITS TO HEALTHQUEST

I hereby authorize HealthQuest, PC to file any medical claims on my behalf. I authorize payment to HealthQuest for services rendered to my dependents or me. I also authorize this office to release any information necessary to expedite insurance reimbursement.

Patient/responsible party

Date

AUTHORIZATION TO FILE WORKMEN'S COMPENSATION AND RELEASE OF ANY MEDICAL INFORMATION REQUIRED

I request the payment of authorized Workmen's Compensation benefits be made on my behalf to HealthQuest, PC for any services furnished to me. I authorize any holder of medical information about me to be released to the Workmen's Compensation Carrier and its agents for any needed information to determine these benefits and for the benefit payable for related services. I authorize HealthQuest PC to send such information. I, further, authorize HealthQuest, PC to send any psychotherapy notes that may be requested by Workmen's Compensation and its agents. This release shall be in effect for the entirety of my treatment at HealthQuest. I agree to pay for services rendered that are not covered by Workmen's Compensation such as missed appointments, telephone consults, completion of disability forms, legal dispositions, non-routine medication refills calls as outlined in the practice policy, and any other forms that are non-routine.

Patient/responsible party

Date