

# MEDICAL RELEASE

## IF YOU ARE A MEDICARE PATIENT PLEASE SIGN BELOW

I, patient, request the payment of authorized Medicare benefits be made on my behalf to HealthQuest 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 benefits payable for related services. I authorize HealthQuest to send such information. I, the patient, also authorize HealthQuest to send any information authorized by Medicare and the Medicare administration to release any information regarding Medicare claims for services provided. 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, or other related forms. 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 co-payment or deductibles Medicare states I owe.

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THE PATIENT/RESPONSIBLE PARTY

DATE

## If you have insurance other than Medicare, please sign below

This is your authorization to release medical information to your insurance carriers or your attorney if liability related, or your employer and their workman's compensation carrier if this is a job related injury. Also by signing this agreement, I agree for my insurance carrier and intermediaries to issue payment checks directly to HealthQuest. A copy of this signature is as valid as the original and is valid for the entire treatment period.

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THE PATIENT/RESPONSIBLE PARTY

DATE: