PAUL M POPPER, MD, PA

CONSENT FOR TREATMENT

PATIENT_____DATE_____TIME_____

1. **CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** I authorize Paul M. Popper MD, PA to furnish the necessary medical or surgical treatments or procedures, including diagnostic, x-ray and laboratory procedures, anesthesia, hospital services, drugs and supplies as may be ordered by attending physician(s), his assistants or his designees. I am aware the practice of medicine and surgery is not an exact science and I acknowledge no guarantees have been made to me as to the results of treatment, diagnostic procedures or examinations by Paul Popper MD, PA.

2. **STATEMENT OF FINACIAL RESPONSIBILITY:** I agree to pay Paul Popper, MD, PA for any and all charges for the services rendered. All accounts are due at time of service. However, I understand Paul Popper, MD, PA may accept assignment of insurance benefits in lieu of an equal amount of payment.

   I further understand that Paul Popper, MD, PA will attempt to collect the assigned insurance benefits. However, the full amount due will still be my responsibility. I realize that Paul Popper, MD, PA may take whatever steps necessary to collect the balance due, including use of a collection agency. I agree to pay all collection costs including attorney fees on appeal.

3. **ASSIGNMENT OF INSURANCE BENEFITS:** In consideration of Paul Popper, MD, PA services to be received, I assign Paul Popper, MD, PA the amount due to me or that becomes due to me under policies mentioned on the reverse side of this form. I authorize and direct payments to be made directly to Paul Popper, MD, PA. In the event payment is received by Paul Popper, MD, PA from any other source for Paul Popper, MD, PA services. I authorize application of the proceeds to any other Paul Popper, MD, PA bill of mine or any member of my family for whose hospital bills I would be legally responsible, subject to the rules of coordination of benefits, if applicable. I also recognize that if a payment is made directly to me by the insurance company, the amount received up to the amount of the Paul Popper, MD, PA bill for the patient services received is the property of Paul Popper, MD, PA and should be paid to Paul Popper, MD, PA immediately. I understand I am personally liable to Paul Popper, MD, PA for charges not paid by this assignment. I also assign the rights to payment due to me for medical and/or surgical services under said policies to the radiologist, pathologist, anesthesiologist, cardiologist, neurologist, speech pathologist, and audiologist involved in my care. I authorize payment to the above physicians and practitioners for charges not covered under this authorization.

4. **AUTHORIZATION FOR RELEASE OF INFORMATION:** I Authorize Paul Popper, MD, PA to release any information, including information regarding diagnosis and treatment requested by the insurance company, necessary to collect benefits under the policies stated at the time of admission, or any policies that I subsequently make claim against for hospital services, including related physicians services on this or a released date of service. This authorization includes, but is not limited to, the release of information relating to drug, alcohol and/or psychiatric treatment. I further authorize any physician or institution that attended this patient to furnish medical records or information that may be requested by Paul Popper, MD, PA or attending physician.

THIS FORM HAS BEEN EXPLAINED TO ME AND I ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS.

Signature_____ _____ _____

Patient, next of kin or legal guardian — **Relationship to patient**

_____ _____

Witness — **Date**

LIFETIME ASSIGNMENT OF MEDICARE BENEFITS:

1. **ACKNOWLEDGEMENT OF MEDICARE:** I certify I am a participant in a Medicare program and I am not enrolled in a health maintenance organization (HMO), or any other prepaid group practice. I understand if it is found I am a participant in any of the above mentioned practices, I will be considered a self-pay patient and required to pay in full immediately.

2. **PATENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify the information given to by me in applying for payment under title XVIII 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 of Professional Review Organization, any information need for this or a related Medicare claim. I request payment of authorized benefits be paid on my behalf. I assign the benefits payable for physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand I am responsible for any deductible and co-insurance amounts and any personal charges incurred. I permit a copy of this authorization to be used in place of the original and I request payment of authorized benefits be paid on my behalf.

Signature_____ ____ _____

Patient, next of kin or legal guardian — **Relationship to patient**

_____ _____

Witness — **Date**

If this account should go to collection, patient will be responsible for all reasonable collection fees, court costs and/or attorney fees.

Name of Beneficiary_____

Health Insurance Claim Number_____

Medigap Policy Number_____

I request that payment of authorized Medigap benefits be made on my behalf to Paul Popper, MD, PA for any services furnished me by Paul Popper, MD, PA I authorize any holder of Medicare information about me to release to Paul Popper, MD, PA any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically._____