WICHITA FAMILY MEDICINE SPECIALISTS, LLC

# ONE TIME AUTHORIZATION

***PLEASE READ AND SIGN THE FOLLOWING TO HELP US WITH YOUR INSURANCE FILING***

I hereby authorize Family Medicine Specialists to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to same all payments for medical services rendered to me. I understand that my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to Family Medicine Specialists. I also authorize Family Medicine Specialists to perform any treatment which is considered necessary by the physician. A photocopy of the authorization and assignment shall be considered as valid as the original.

PATIENT OR GUARDIAN SIGNATURE _____ DATE SIGNED _____

| | YES | NO |
|---|---|---|
| 1. Are you a veteran? | _____ | _____ |
| a. Did the Veterans Administration refer you here for treatment? | _____ | _____ |
| b. Does the patient have a Veterans Administration "Fee Basis ID Card"? | _____ | _____ |
| 2. Do you have a Federal Black Lung card? | _____ | _____ |
| 3. Was this an injury? | _____ | _____ |
| If yes, was it: Work related_____ Auto_____ Injured in own home_____ Other_____ | | |
| 4. Is the patient covered by any employer's health insurance plan through their own employment or that of a family member? | _____ | _____ |

**MEDICARE PATIENT'S ONLY:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family Medicine Specialists for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT OR GUARDIAN SIGNATURE _____ DATE SIGNED _____

| NAME OF BENEFICIARY | HICN - MEDIGAP POLICY NUMBER |
|---|---|
| | |

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Family Medicine Specialists for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company any information needed to determine those benefits or the benefits payable for related services.

PATIENT OR GUARDIAN SIGNATURE _____ DATE SIGNED _____