ASSIGNMENT OF BENEFITS

I hereby assign to Saint Luke's Medical Group my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to Saint Luke's Medical Group. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering services provided by Saint Luke's Medical Group.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signed:_____ Date:_____
Signature of Patient or Legal Representative

Patient **Printed** Name:_____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, BILLING, OR HEALTH CARE OPERATIONS

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that Saint Luke's Medical Group reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Records may be needed in order to process a claim for medical services. I authorize Saint Luke's Medical Group to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.
I understand that by signing below, I am authorizing the release of all or any part of my medical record for the purpose of my **treatment, billing, or pertinent health care operations.** This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.

_____ _____
Patient or Legal Representative **Signature** Date Witness Date

Patient's **Printed Name**:_____

Patient's Date of Birth:_____