

**OB/Gyn Associates of Denton  
3537 South I-35 East  
Suite 200  
Denton, TX 76210**

**Authorization**

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for out office to file your insurance; however you are responsible for your co-pay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I \_\_\_\_\_ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistants and nurse practitioners and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

I request that payment of authorized Medigap (Medicare supplement) benefits be made on my behalf to the provider for any services furnished to me by the provider. I authorize any holder of medical information about me; to release to Medigap Insurer \_\_\_\_\_ any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

**MEDICARE LIFETIME AUTHORIZATION  
HIC# \_\_\_\_\_**

**Medicare Certification for payment**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries of carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me.

Request that this authorization also apply to all other insurance.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Title or Relationship: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Address: \_\_\_\_\_

If signed by other than the beneficiary, state the reason the patient was unable to sign:  
\_\_\_\_\_