Twin Lakes Medical Foundation. Inc.

(This form is used for billing purposes and authorization for consent to treat only. All patients will be ask to update this form on a yearly basis.)

The statements below are in accordance to HIPAA Compliance. You may refuse any statement by initialing to the side of the statement.

Assignment of Insurance

I hereby authorize direct payment of surgical/medical benefits to Twin Lakes Medical Foundation for services rendered by Twin Lakes Medical Foundation facilities or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. Refusal_____

Authorization to Release Information

I hereby authorize Twin Lakes Medical Foundation, Inc. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of these assignments shall be valid as the original. Refusal _____

Consent for Treatment

I have voluntarily consented to care that could involve diagnostic testing, procedures and/or medical treatment as ordered by the providers and/or facilities associated with Twin Lakes Medical Foundation, Inc or Twin Lakes Regional Medical Center. I am also financially responsible for any balance not covered by my insurance or in the absence of insurance, which ever the case may be. Refusal _____

My signature below is recognition that I understand and have agreed to the above unless I have utilized my right to refuse by initialing statements above.

Patient Signature: _____ Date: _____

If the patient is under the age of 18 or you are a legal guardian of the patient please print and sign your name below:

Print Parent Name/Guardian: _____

Parent/Guardian Signature: _____ Date: _____