Cypress Physicians Association

Assignment and Release

I, the undersigned, have coverage with_____
and assign directly to Cypress Physicians Assoc. all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature for all insurance submissions.

I further authorize the use of this signature as Treatment Authorization and give permission to Cypress Physicians Assoc. to give me reasonable and proper medical care based on today's standards.

I further authorize the use of this signature as Lab and Insurance Submission Consent and give permission to Cypress Physicians Assoc. to submit blood specimens to the lab of choice for analysis and study. I also authorize the submission for payment to my insurance for charges incurred for said labs and further agree to full responsibility for payment of any non-covered services.

Medicare Participants: I request that payment of the authorized Medicare benefits be made on my behalf to Cypress Physicians Assoc. for any services rendered by the physicians of this group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits of the benefits payable for related services. I understand that my signature request that payment be indicated in item 9 of the HCFA-1500 form, or elsewhere on other claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. The physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

As responsible party for this account I agree to pay the balance due. Should the billing department need to contact me in regards to this account and are unable to reach me by mail or home phone, then I may be reached at the work place.

Patient name (printed):_____ DOB:_____

Signature: _____ Date:_____
(Patient or person authorized to give consent)