R Family Medical Group
Here To Serve Your Family

Returning Patient Demographics Form

Patient Name: _____ Date of birth: _____

_____

Home address City State Zip

Social Security #: _____ Cell or Home Phone: _____

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company _____, and my secondary insurance (if any) _____ be made directly to *David A. Ramos, MD PA dba R Family Medical Group* for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize *David A. Ramos, MD PA dba R Family Medical Group* to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of *David A. Ramos, MD PA dba R Family Medical Group*. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release *David A. Ramos, MD PA dba R Family Medical Group*, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

MEDICARE ASSIGNMENT OF BENEFITS/ RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to David A. Ramos, MD PA DBA R Family Medical Group for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment. I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to act in reference to payment for treatment services.

2. I agree to participate and assist *David A. Ramos, MD PA dba R Family Medical Group* or its designated representatives with any appeal process necessary to collect payments for services rendered.

3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.

4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.

5. *David A. Ramos, MD PA dba R Family Medical Group employee i*s acting in filing for insurance benefits assigned to *David A. Ramos, MD PA dba R Family Medical Group* and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).

6. A firm contracted by *David A. Ramos, MD PA dba R Family Medical Group* for billing and collection purposes may do billing.

7. *David A. Ramos, MD PA dba R Family Medical Group* is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.

8. Should an overpayment take place a refund check will be mailed to the authorized party that is due the overpayment.

(Continued on next page)

9. *David A. Ramos, MD PA dba R Family Medical Group* shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Staff Print Name: _____ Date: _____

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