ASSIGNMENT OF BENEFITS & RELEASE OF FINANCIAL INFORMATION

Patient Name: ________________________________ Date: ________________

Heart of Georgia Cardiology
2064 Vineville Ave.
Macon, GA 31204

Assignment of Insurance Benefits: *I hereby authorize payment directly to the above-named providers, of any and all insurance benefits for this visit, hospital inpatient or outpatient stay, otherwise payable to or on behalf of patient or to me, and authorize release of information requested by the patient's insurance company(ies).*

Signature: ______________________________________ Date: ________________
(Patient or authorized representative)

Insured:

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(Address if signed by Authorized Representative) (Relationship to Patient)

In consideration of hospital or outpatient services and services rendered by above named providers to be rendered to above-identified patient, I, or we, jointly or severally, do hereby agree to pay any and every account presented to me, or us, for service or services given in conjunction with admission as identified above and fully understand that I am responsible for any charges not covered by the above assignment. I hereby authorize Heart of Georgia Cardiology to release information to my insurance carrier or third party payor for the purpose of coordination of benefits.

Signature: ______________________________________ Date: ________________
(Patient or authorized representative)

Assignment of Medicare and/or Medicaid Benefits: *I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or Georgia Medial Care Foundation or its intermediaries or carries any information needed for this or a related Medicare and/or Medicaid 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 authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment to me.*

Signature: ______________________________________ Date: ________________
(Patient or authorized representative)