DIRECT PAYMENT AUTHORIZATION AND CONSENT FORM FOR PHYSICIAN

PEER PAIN MEDICINE: Gerald L. Peer, MD and Matthew G. Peer, MD (Tax ID: 45-4767525)

Patient Name: _____
Last Name First Name Middle Initial

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I consent that information contained in my medical record may be furnished to any insurance carrier, hospital service corporation or medical expense indemnity company which may be liable for my medical expenses under a specific contract. I also consent to release of pertinent information in my medical record to physicians or other health care professionals as required for continuity of medical care. Such information shall be confidential.

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payment to **Peer Pain Medicine**, of any insurance benefits payable to me but not to exceed the regular and customary charges for the services. I hereby assign transfer and set over sufficient moneys and/or benefits to which I may be entitled from government agencies, insurance companies, and others liable for my health care to cover the cost of care rendered to me or my dependents and authorize payment to the physician directly. I understand that I am financially responsible for any amounts not covered by my plan or this authorization.

MEDICARE BENEFITS (if applicable): I certify that the information given by me for application for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information to release to the Social Security Administration, or its carriers, any information required to process my Medicare claim. I request that payment under the Medical Insurance Program be made to **Peer Pain Medicine** for services provided to me.

ASSIGNMENT FOR NO-FAULT or WORKERS COMPENSATION

(If your primary insurance is No-Fault or Workers Compensation, you MUST also complete this section.)

Date of Injury/Accident:	_____	Claim Rep Name:	_____
Date of Birth:	_____	Social Security Number:	_____
Insurance Carrier:	_____	WCB or Policy #:	_____
Case #:	_____	Insurance Telephone #:	_____

In consideration of services rendered to the above named patient I hereby authorize direct payment in the name of the above physician of any and all first party no-fault or compensation insurance benefits to which I may otherwise be entitled for services rendered by the physician, but not to exceed the physician's regular charges for the services.

In the event that the physician's charges are outstanding and I fail to file an application for benefits under the NYS No-Fault and Compensation Insurance Laws, I hereby authorize the physician to file such a claim on my behalf so that the physician may realize payment of his charges. I understand that if the physician does not receive payment from the insurer, I am personally responsible for the payment of the physician's charges.

FINANCIAL AGREEMENT: I the undersigned agree that, in consideration for the services rendered to me, I am fully responsible for the full amount of the bill (charges). Should my account be turned over for collection, I agree to pay any fee over and above that of the bill. Interest may be charged at the IRS legal rate should my account become delinquent.

I, the undersigned, certify that I have read the foregoing, understand and accept its terms.

Signed: _____ Date: _____

Witness: _____ Date: _____