

AUTHORIZATIONS

PHOTOGRAPHIC CONSENT:

I hereby consent to be photographed for medical and/or scientific purposes. I understand that I may be photographed before, during, and/or after surgery and that this is an important part of my permanent record.

DATE ___ / ___ / ___ SIGNED: _____

AUTHORIZATION OF PAY BENEFITS TO PHYSICIAN:

I hereby authorize my insurance benefits payable directly to Brent Moelleken, M.D., and I am financially responsible for all non-covered services. I authorize Brent Moelleken, M.D. to release to the insurance company any information required to process this claim.

DATE: ___ / ___ / ___ SIGNED: _____

AUTHORIZATION TO PAY BENEFITS TO SURGICAL FACILITY:

I hereby authorize my insurance benefits payable directly to Spalding Outpatient Surgery Center, and I am financially responsible for all non-covered services. I authorize Spalding Outpatient Surgery Center to release to the insurance company any information to process this claim.

DATE: ___ / ___ / ___ SIGNED: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the above named physician to release any information acquired in the course of my examination or treatment to their physicians. This includes Peer Review by selected physicians to ensure high quality of medical care as mandated.

DATE: ___ / ___ / ___ SIGNED: _____

MEDICARE:

I request that payment of authorized Medicare benefits be made to either to me or on my behalf to Dr. Brent Moelleken, or the Spalding Outpatient Surgical Center, for any services furnished me by that doctor or group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor or group any information regarding my Medicare claims under Title XVIII of the Social Security Act.

DATE: ___ / ___ / ___ SIGNED: _____