FOR ALL INSURANCE, PLEASE SIGN THIS SECTION

AUTHORIZATION TO PAY BENEFITS TO HEALTHQUEST

I hereby authorize HealthQuest, PC to file any medical claims on my behalf. I authorize payment to HealthQuest for services rendered to my dependents or me. I also authorize this office to release any information necessary to expedite insurance reimbursement.

_____ _____

Patient/Responsible Party Date

IF YOU HAVE MEDICARE, PLEASE SIGN THIS SECTION.

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request payment of authorized Medicare benefits be made on my behalf to HealthQuest for any services furnished to me. I authorize any holder of my medical information to release it to the Healthcare Finance Administration and its agents for the purpose of determining benefits and for the benefits payable for related services. I authorize HealthQuest to send such information. This release shall be in effect for the entirety of my treatment at HealthQuest. I agree to pay for services rendered that are not covered by Medicare such as missed appointments, telephone consults, completion of disability forms, legal depositions, non-routine medication refill calls as outlined in the practice policy, and any other non-routine forms. I also agree that I will pay for any labwork required not covered by Medicare. I also agree to pay any coinsurances or deductibles owed.

_____ _____

Patient/Responsible Party Date

IF WE ARE FILING WORKMEN'S COMP AS YOUR INSUANCE CARRIER, PLEASE SIGN THIS SECTION

AUTHORIZATION TO FILE WORKMEN'S COMPENSATION AND RELEASE OF ANY MEDICAL INFORMATION REQUIRED

I request the payment of authorized Workmen's Compensation benefits be made on my behalf to HealthQuest for any services furnished to me. I authorize any holder of medical information about me to be released to the Workmen's Compensation Carrier and its agents for any needed information to determine these benefits and for the benefit payable for related services. I authorize HealthQuest to send such information. I further authorize HealthQuest to send any treatment notes that may be requested by Workmen's Compensation and its agents. This release shall be in effect for the entirety of my treatment at HealthQuest. I agree to pay for services rendered that are not covered by Workmen's Compensation such as missed appointments, telephone consults, completion of disability forms, legal depositions, non-routine medication refills as outlined in the practice policy, and any other forms that are non-routine.

_____ _____

Patient/Responsible Party Date