

Women's Pelvic Health & Continence Center
Gregory J. Bailey M.D.
6440 West Newberry Rd., Suite 409
Gainesville, Florida 32605
352-333-6161

INSURANCE INFORMATION

Policy #

Group #

Name of Insurance through Employer:		
Name of Insurance through Spouse's Employer:		
Name of Insurance through Parent:		
If minor, list parents name and address:		

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment direct to any physician examining or treatment of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying or payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I permit a copy of these authorization and assignments to be used in place of the original which is on file at the physician's office. If Medicare patient, I understand this is a lifetime authorization.

I AGREE THAT SHOULD THE AMOUNT OF THE INSURANCE BENEFITS BE INSUFFICIENT TO COVER THE EXPENSES, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. I WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT DUE FOR PROFESSIONAL SERVICES RENDERED IF THE EXPENSE IS NOT COVERED BY MY POLICY.

NOTE: YOU WILL RECEIVE A SEPARATE BILLING FROM OUTSIDE LAB, PHYSICIAN OR HOSPITAL FOR INTERPRETATION OF RESULTS OF LAB WORK AND/OR PATHOLOGY SPECIMENS COLLECTED IN OUR OFFICE.

Patient signature: _____ Date: _____