

Lifetime Authorization

Insurance Assignments and Authorization to Release Information

- I. **Release of Information** - I hereby authorize Harvey Y. Hsiang, MD, PhD, Y. Henry Hsiang, MD, PhD, and/or his authorized employees to release any medical information (including psychiatric, alcohol, or drug-related records) necessary for processing my insurance claims.
- II. **Physician Insurance Assignment** - I hereby request, authorize, and direct Harvey Y. Hsiang, MD, PhD, Y. Henry Hsiang, MD, PhD, and/or his authorized employees to file insurance claims on my behalf to all applicable third payers. I hereby assign all benefits due directly to Harvey Y. Hsiang, MD, PhD or Y. Henry Hsiang, MD, PhD. In the event that my policy prohibits payment to be made directly to the doctor, I direct my insurance company to send all checks to me in care of Emerald Coast Cancer Center at the above address.
- III. **Medicare/Medicaid** - I authorize Harvey Y. Hsiang, MD, PhD., Y. Henry Hsiang, and/or his employees to bill Medicare and/or Florida Medicaid for any benefits that may be due under these programs. I certify that the info given to me pertaining to Medicare/Medicaid is correct. I hereby assign to Harvey Y. Hsiang, MD, PhD. or Y. Henry Hsiang MD, PhD any benefits that are due under these programs. In the event that I am deemed no longer eligible for coverage under these programs, I acknowledge my responsibility for any unpaid claims.
- IV. **I permit a copy of this authorization and assignment to be used in place of the original which is on file at the physician's office.** *This release will remain in effect until revoked by me in writing.*

I understand that you file insurance as a courtesy and convenience to me. I realize that I am responsible for any copayments, deductibles, non-covered services, and any claims not covered by my insurance or third party payers within 30 days from the date filed. All payments are required on a 30 day cycle, unless prior arrangements have been made and documentation signed by both myself and one of the doctor's representatives.

If this account is assigned to a collection agency or attorney for collection and/or Suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. The undersigned guarantor secures and warrants the timely payment of the obligation of the patient as set forth above.

Date: _____

Patient Name: _____

Policyholder/Guarantor: _____

Policyholder/Guarantor Address: _____

Policyholder/Guarantor Home #: _____

Policyholder/Guarantor Work #: _____