HEMOPHILIA OUTREACH CENTER

SIGNATURE ON FILE

For Insurance Billing

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the Hemophilia Outreach Center.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the Hemophilia Outreach Center for services provided.

SIGNED: _____ DATE: _____

For Medicare Patient's Only:

Name: _____ Medicare No**.** _____
I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Hemophilia Outreach Center for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it. *

SIGNED_____ DATE: _____

*If you're a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.

Consent to Treat

I consent to the use or disclosure of my protected health information by Hemophilia Outreach Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Hemophilia Outreach Center. By signing this form, I give consent for Hemophilia Outreach Center to use and/or disclose my health information for treatment, payment or health care operations.

_____ _____
Signature of Patient/Representative Date

2060 Bellevue Street● Green Bay, WI 54311 ● Phone: 920-965-0606 ● Toll Free: 800-992-6026 ●Fax: 920-965-0607