Health Care for the Entire Family

ROANE COUNTY FAMILY HEALTH CARE

146 Williams Drive, Spencer, WV 25276
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Tax ID: 55-0627933

www.rcfhc.org

AUTHORIZATION AGREEMENT

ASSIGNMENT OF INSURANCE PAYMENT AND RELEASE OF MEDICAL INFORMATION

Patient Name:_____

Patient Account #:_____

I consent for treatment and request that payment of authorization of Medicare and other insurance company benefits be made to Roane County Family Health Care, Inc. for any services furnished to me by this practice. Regulations regarding Medicare benefits apply. I further authorize the release of medical information by this practice to Social Security Administration, Health Financing Administration or its intermediaries, or any other insurance company with which a claim for health care benefits may be billed.

Finally, I understand the fact that ultimate responsibility for all charges incurred on my account is mine, and I agree to pay all deductibles, co-insurance changes, and charges for all non-covered and denied services.

Patient Signature:_____ Date:_____

Guarantor's Signature:_____ Date:_____