

Robert A.M. Gardère, M.D., F.R.C.S.(C), F.A.C.S.

Hillcrest Medical Tower
3115 Pine Avenue, Suite 908
Waco, Texas 76708
(254) 752-2575/Fax (254) 752-0188

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____ Chart Number: _____

ASSIGNMENT OF BENEFITS AUTHORIZATION:

I request that payment of insurance benefits be made payable in my behalf to Robert A.M. Gardère, M.D. for services rendered to me. I agree to pay for all charges incurred or for those charges in excess of any benefits paid by my insurance.

AUTHORIZATION TO RELEASE PATIENT INFORMATION:

I also authorize the RELEASE of any medical information necessary to process my claim. This assignment of benefits and authorization to release information shall be valid for the duration of my treatment by the above referenced provider.

A photocopy of this assignment and RELEASE shall be as effective and valid as an original.

If my insurance company requires that preoperative and/or postoperative photos be sent for their use in order to process this claim, I also authorize the RELEASE of any photographs necessary to process my claim.

If my insurance requires second surgical opinion and/or pre-certification for admissions, and I neglect to inform you of such requirement, I agree to pay any and all amount of benefit reduction. (Please be sure to check your insurance booklet or contact your personnel department.)

AUTHORIZATION TO RELEASE PATIENT INFORMATION TO FAMILY/FRIENDS:

In order to comply with privacy issues, I hereby authorize Robert Gardère, M.D. to give my patient information (including but not limited to diagnosis, current and potential treatment options, medications prescribed, billing) to the following individual/individuals. This authorization is considered in force until Dr. Gardère is otherwise notified in writing by me.

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Relationship to Patient: _____

Relationship to Patient: _____

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Relationship to Patient: _____

Relationship to Patient: _____

In signing this form, I acknowledge having read the above privacy authorization statements, and I fully understand and hereby authorize release of my patient information as so stated above:

Patient's Signature

1) Combined Acceptance Corporation

Toll-free number: 1-888-405-8140

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