Salisbury Psychiatric Associates, PC

ASSIGNMENT AND RELEASE

I the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **SALISBURY PSYCHIATRIC ASSOCIATES, P.C.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of insured/Guardian Date

MEDICAID / MEDICARE AUTHORIZATION

I request that payment of authorized Medicare/Medicaid benefits to me or on my behalf to **SALISBURY PSYCHIATRIC ASSOC., P.C.** for any services furnished me by that physician. I authorize any holder of medical information about me released to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

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