TEXAS
INFECTIOUS DISEASE
INSTITUTE

PATIENT AUTHORIZATION FORM

1. Authorization to Release Information:

   I authorize Serge Lartchenko, M.D., to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payer for the purpose of obtaining Payment on account of Serge Lartchenko, MD., (2) any other person(s) or entities financially Responsible for the patient's Care or Treatment, and (3) representatives of Local, State, or Federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. Assignment of Benefits:

   Please remember that insurance is considered a method of reimbursing the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance. In order to control your cost of billing, we request that charges for office visits be paid at the beginning of each visit. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees for costs of collection.

   I understand that I am responsible for providing Serge Lartchenko, M.D., all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

   I hereby assign all medical and/or surgical major medical benefits to which I am entitled including Medicare, private insurance and other health plans to Serge Lartchenko, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said Insurance. I hereby authorize said assignee to release all information necessary to secure payment.

3. Medicare / Medicaid Assignment of Benefits:

   a) I certify that the information given by me in applying for payment under Title XVll of the Social Security Act is correct. I authorize the release of information concerning me to Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf or assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

   b) I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount allowable and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payables for non-covered services are due and payable prior to each office visit unless prior payment arrangements have been made.

Patient Signature: _____ Date: _____