

ADVANCED LAPAROSCOPIC ASSOCIATES, P.C.
CONSENT FOR CARE AND TREATMENT

I am presenting myself for services to the office and I voluntarily consent to the rendering of such care including medical treatment by authorized agents and employees of the office and its medical staff or their designees, as may in their professional judgment be deemed necessary or beneficial to my well being.

DATE

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE.

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

I hereby authorize release of information in relation to medical treatment by Joseph C. Moran, MD to the insurance carriers, or others who are financially liable for my medical care all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

DATE

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Joseph C. Moran, MD all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with _____ insurance company.

DATE

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of, or been offered the opportunity to receive. Joseph C. Moran, MD Notice of Privacy Practices.

DATE

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE.

**FOR PATIENTS ENTITLED TO MEDICARE BENEFITS LIFETIME
AUTHORIZATION**

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this on my behalf to the physician or organization furnishing the services provided to me. I authorize any holder of medical information about me to release to the MEDIGAP insurer any information needed to determine these benefits or the benefits payable for related services. I request that payment under the medical insurance program be made to any physician accepting assignment for services provided to me.

DATE

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE