AUTHORIZATION/RESPONSIBILITY AGREEMENT

I have requested that my Physician's office bill my Insurance Company on my behalf. I clearly understand that it is my responsibility to make sure that this bill is paid. I also understand that I am fully responsible for any incurred services that are not paid by my Insurance Company albeit a co-pay, and/or a non-covered service, and/or the Physician being non-participant in my Insurance Plan.

In order to process a claim for benefits, I authorize to release to any of my Insurance Companies, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNED:_____ DATE:_____

MEDICARE PATIENTS ONLY-PLEASE SIGN BELOW
"One time authorization agreement"
Statement to permit payment of Medicare
Benefits to Providers, Physicians and Patients

_____ _____
Name of Beneficiary HIC Claim Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to be by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

_____Payment to Patient _____Payment to Provider

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____

Provider Name: **Malgorzata Sobilo, M.D.**

For services furnished to inpatients of a Hospital of SNF, this request is effective for any period of confinement. For services furnished by a Provider or on an outpatient basis, this request is effective until revoked by the Beneficiary.