PATIENT SIGNATURE ON FILE FORM

Innovative Medical Associates, LLC

Medicare I request that payment of authorized Medicare benefits be made either to me or on my behalf to Innovative Medical Associates, LLC and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to my self or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐Y ☐ N	Has treatment been authorized by the V.A.?	☐Y ☐ N
Do you or your spouse have other insurance?	☐Y ☐ N	Are you covered under the Black Lung Program?	☐Y ☐ N
Are you disabled or have end stage renal disease?	☐Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐Y ☐ N
Is illness/injury the result of an auto accident?	☐Y ☐ N	Is there insurance coverage primary to Medicare?	☐Y ☐ N
Did illness/injury occur at work?	☐Y ☐ N	Is there employer supplemental coverage secondary to Medicare?……	☐Y ☐ N

Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Innovative Medical Associates, LLC for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap Coverage) any information Insurance) needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Commercial ASSIGNMENT OF INSURANCE BENEFITS – I hereby authorize payment directly to Innovative Medical Associates, LLC for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

General RELEASE OF INFORMATION – Innovative Medical Associates, LLC may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Workers Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Main Line HealthCare and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

GUARANTEE OF ACCOUNT – For and in consideration of services rendered by Innovative Medical Associates, LLC to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____

Patient Signature Date

_____

Patient's Agent Representative and Guarantor Signature Date