TruCare Internal Medicine & Infectious Diseases

Assignment of Benefits

I hereby authorize TruCare to release information to insurance carriers concerning my illness and treatments for the purpose of payment. I also authorize my insurance company, including Medicare, to make payments to TruCare Internal Medicine and Infectious Diseases (TruCare) for medical or surgical services or items rendered to me or my dependent by Trucare. Should my insurance carrier deny payment, I authorize TruCare to release any and all of my records to my insurer, or any third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. I understand that it is my responsibility to update any and all personal, insurance, and health information. I understand I am responsible for any amount not covered by my insurance including co-pays, deductibles, and non-covered services.

Name: _____ DOB: _____
(Print)

Signature: _____ Date: _____

Consent for Treatment

I consent to examination and/or medical care as prescribed by the physician. I understand sample medications are for patient use and shall be dispensed in non-child proof containers. I understand I will be instructed on the use and indication of any sample medication(s) and possible side effects or adverse reactions. This authorization is in force unless revoked in writing.

Signature: _____ Date: _____

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