

**DAVID B. ETHIER, MD, P.A.**

**MEDIGAP POL:** I request that payment of Authorized MEDIGAP benefits be made on my behalf to Dr. David B. Ethier, M.D, P.A. I authorize any holder of medical information about me to release to the insurance company any information needed to determine these benefits and make payable these benefits for related services. I understand that I do not need to provide my supplemental insurer with information concerning this medical claim, because my signing this authorization will cause medicare payment authorization to cross cover automatically.

**\*\*Signature\_\_\_\_\_Date:\_\_\_\_\_**

**RELEASE OF INFORMATION:** I Authorize any holder of medical or other information about me to be released to my Physician, insurance carrier, SSI administration, or the billing agent, for this or a related claim. I agree these records may be sent by fax.

**\*\*This authorization places no restrictions on any information to be released, including treatment for alcohol or drug abuse. \*\*I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that insurance is considered a method of reimbursement and a contract between myself and my insurance company, and is not a substitute for payment. I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by assigned insurance within a reasonable period of time not to exceed 60 days. In the event of non-payment, the patient shall be responsible for all cost incurred in collecting the amount due for services rendered, including reasonable attorney's fees, with the amount due and the costs accruing interest at the rate of 20% per annum.**

**\*\*\*WE MUST HAVE THE SIGNATURE OF THE RESPONSIBLE PARTY FOR SERVICES RENDERED.**

**\*\*Signature\_\_\_\_\_Date:\_\_\_\_\_**