IDX Account#:

JUP Patient Signature on File Form

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson University Physicians 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 Centers for Medicare & Medicaid Services 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 myself 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

Do you or your spouse have other insurance?................. ☐ Y ☐ N

Are you disabled or have end stage renal disease?......... ☐ Y ☐ N

Is illness/injury the result of an auto accident?................. ☐ Y ☐ N

Did illness/injury occur at work?...☐ Y ☐ N

Has treatment been authorized by the V.A.?.....................☐ Y ☐ N

Are you covered under the Black Lung Program?.............☐ Y ☐ N

Is there Medigap coverage secondary to Medicare?.........☐ Y ☐ N

Is there insurance coverage primary to Medicare?............☐ 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 Jefferson University Physicians for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information 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 Jefferson University Physicians 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 agreement, 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

I hereby authorize Jefferson University Physicians to disclose to my insurance company(s) copies of my medical records(s) to obtain payment for services or as part of a payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Jefferson University Physicians to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

Financial Agreement

In consideration of the services rendered to the below named patient, the undersigned agrees to pay Jefferson University Physicians in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Jefferson University Physicians may not be deferred for any reason, including pending legal action against other parties, to recover medical costs.

The undersigned certifies that each has read and understands the above terms and conditions.

Patient Name (Please Print)

X

Patient Signature Date

X

Patient's Agent Representative and Guarantor Signature Date