31182 Novi Road
Novi, Michigan 48377
Phone: 248-859-4231 | Fax: 248-277-5789

Authorization to Release Medical Records to Advanced Wound Care & Hyperbaric Medicine

Patient Name:_____

Date of Birth:_____ Social Security Number (last 4 digits only:) _____

RECORDS TO BE RELEASED

For purposes of my evaluation and treatment, Advanced Wound Care & Hyperbaric Medicine will require the following information from my medical records:

All records relating to my condition/diagnosis of: _____

_____,
including without limitation, history and physical, office visit notes, physician consults, radiology and laboratory reports, and reports of other consultations or tests related to my condition.

AUTHORIZATION

I hereby authorize the following provider to release all of my protected health information referenced above to Advanced Wound Care & Hyperbaric Medicine:

Physician/Hospital/Faciliy: _____

Street Address: _____

Phone #: _____ Fax#: _____.

This authorization will remain in effect until I am discharged as a patient of Advanced Wound Care & Hyperbaric Medicine. I understand that I may withdraw this authorization at any time by giving written notice to the Clinic Admistrator at Advanced Wound Care & Hyperbaric Medicine. A photocopy of this authorization is as valid as the original.

Patient Signature:_____ Date: _____

If legal guardian, state relationship: _____

ASSIGNMENT OF BENEFITS
AUTHORIZATION TO RELEASE INFORMATION
FINANCIAL RESPONSIBILITY

Assignment of Benefits

I hereby irrevocably assign and transfer directly to Advanced Wound Care & Hyperbaric Medicine of Michigan and/or its providers (collectively, "Advanced Wound Care & Hyperbaric Medicine of Michigan"), as my designated authorized representative, all right, title, and interest in and all medical benefits and/or insurance reimbursement for all services provided by Advanced Wound Care & Hyperbaric Medicine of Michigan, which are provided in any and all insurance policies and health benefit plans under which I am entitled to services or entitled to recover, regardless of the network participation status of Advanced Wound Care & Hyperbaric Medicine of Michigan. I further assign to Advanced Wound Care & Hyperbaric Medicine of Michigan, as my designated authorized representative, all of my rights to pursue administrative appeals or litigation against such insurance carriers, health plans, and their agents to obtain payment for services rendered by Advanced Wound Care & Hyperbaric Medicine of Michigan, and the right to pursue all other claims, including without limitation ERISA claims, against such insurance carriers, health plans, and their agents. I hereby authorize and direct my insurance carriers, including Medicare, private insurance, and any other health/medical plan, and their agents, to issue payment check(s) directly to Advanced Wound Care & Hyperbaric Medicine of Michigan for services rendered to myself and/or my dependents. **I understand that I am financially responsible to Advanced Wound Care & Hyperbaric Medicine of Michigan for all charges for services, including any amount not paid by my insurance or health plan.**

Authorization to Release Information

I hereby authorize Advanced Wound Care & Hyperbaric Medicine of Michigan to: (1) release all information necessary to process claims to my insurance carrier, health plans, or their agents; (2) process claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process claims for the period of my lifetime. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to Advanced Wound Care & Hyperbaric Medicine of Michigan any and all plan documents, summary benefit descriptions, insurance policies, and/or settlement information upon written request from Advanced Wound Care & Hyperbaric Medicine of Michigan or its attorneys in order to claim such medical benefits or pursue any assigned claims. This authorization to release information will remain in effect until revoked by me in writing.

Financial Responsibility

All services rendered by Advanced Wound Care & Hyperbaric Medicine of Michigan are charged to the patient and are due at the time services are provided, unless other arrangements regarding the date of payment have been made in advance with our financial counselor. Claim forms will be completed to help expedite insurance/health plan payments. **However, the patient is responsible for all charges for services provided by Advanced Wound Care & Hyperbaric Medicine of Michigan, regardless of insurance coverage. I understand that Advanced Wound Care & Hyperbaric Medicine of Michigan is not required to pursue payment from any insurance carrier, health plan, or their agent. Should the account be referred to an attorney or agency for collection, I agree to pay reasonable attorney's fees and collection expenses, whether suit is filed or not.** Delinquent accounts and amounts (those not paid within 30 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I have requested medical services from Advanced Wound Care & Hyperbaric Medicine of Michigan on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred for the services provided. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the Advanced Wound Care & Hyperbaric Medicine of Michigan statement.

A photocopy of this document is to be considered as valid as the original.

By my signature below, I acknowledge that I have read, understand, and agree to all of the provisions of this document.

_____
Print Name of the Patient

_____
Print Name of the Responsible Party/Plan Participants (if different)

_____
Signature of the Patient

_____
Signature of the Responsible Party/Plan Participants (if different)

_____
Signature of the Witness

_____
Date