INSURANCE INFORMATION

Please Print

1st Insurance Co.:______________________________

Claims Address:______________________________

______________________________Zip:__________

Insured Name:____________________DOB:__________

ID#____________________Group#__________

Relationship:____________________SS#__________

2nd Insurance Co:______________________________

Claims Address:______________________________

______________________________Zip:__________

Insured Name:____________________DOB:__________

ID#____________________Group#__________

Relationship:____________________SS#:__________

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may deem necessary to the patient named above.

Parent/Guardian Signature:______________________________ Date:______________

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida Physicians Medical Group/Dr. Michael Baker, MD. I understand and agree that regardless of insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Parent/Guardian Signature:______________________________ Date:______________

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for insurance carriers or for continuing patient care. Any of the classifications may be crossed off if that information is not to be released.

Parent/Guardian Signature: ______________________________ Date:______________

FOR MEDICARE PATIENTS ONLY
LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient Signature/Parent/Guardian or Responsible Party:______________________________Date:______________

We understand that on occasion it may be necessary for your child to be brought to our office for care and treatment by someone other than the named parent or guardian. In that case, we will need your permission to allow that person to seek medical attention for your child in your absence. Please use the space below to supply the name and relationship of any person you would give this permission to.

Name:______________________________ **Relationship:**______________________________

Name: ______________________________ **Relationship:** ______________________________