ST. LUKES MEDICAL GROUP

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION

PATIENT: _____

DATE: _____

I hereby authorize the St. Luke's Medical Group physician to administer/perform any treatment deemed necessary, and authorize release of information needed to secure payment/ I authorize that all benefits paid by my insurance company be paid directly to St. Luke's Medical Group, and understand that I am financially responsible for all charges incurred that are not covered by my insurance. The patient/guarantor(s) acknowledge and agree if the account is forwarded to an outside collection agency a collection fee of 10% will be added to the principal of all unpaid delinquencies. If the account is referred to an attorney, the patient will be responsible to pay all reasonable attorney's fees and court costs.

ANY REVISIONS OR ALTERATIONS OF THIS DOCUMENT WILL NOT BE ACCEPTED, AND ANY SUBSEQUENT TREATMENT PROVIDED WILL NOT BE DEEMED A WAIVER OF ANY OF THE FINANCIAL RESPONSIBILITY TERMS.

In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and other health care providers and/or organizations who will be providing subsequent monitoring of care or treatment in connection with care provide by the St. Luke's Medical Group.

Signature of Responsible Party: _____

Date Signed: _____