

## PATIENT SIGNATURE ON FILE FORM

---

**Medicare** I requested that payment of authorized Medicare benefits be made either to me or on my behalf to Rose Tree Medical and/or to individual Attending Physician. For any services furnished to me by that Physician. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits and/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?	Yes	No
Do you or your spouse have insurance?	Yes	No
Are you disabled or have end stage renal disease?	Yes	No
Is illness/injury the result of an auto accident?	Yes	No
Did illness/injury occur at work?	Yes	No
Has treatment been authorized by the V.A.?	Yes	No
Are you covered under the Black Lung Program?	Yes	No
Is there Medigap coverage secondary to Medicare?	Yes	No
Is there employer supplemental coverage secondary to Medicare?	Yes	No
Is there insurance coverage primary to Medicare?	Yes	No

---

**Medigap** I request that payment of authorized Medigap benefits be made to either me or on my behalf to Rose Tree Medical for any service furnished to me by the Physician. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ (Name of 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, 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 Rose Tree Medical for medical benefits including and/or 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 assignment, I understand and agree that I am financially responsible to the above party for charges not paid under the insurance policy. I permit a copy of this authorization to be used in place of the original.

---

**General** RELEASE OF INFORMATION – Rose Tree Medical may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Workers Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Rose Tree Medical and/or its Physicians. This authorization does not cover requests from other parties seeking information regarding my account.

GUARANTEE OF ACCOUNT – For and in consideration of services rendered by Rose Tree medical to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S AGENT REPRESENTATIVE & GUARANTOR SIGNATURE

\_\_\_\_\_  
DATE