JSAPA
Patient Responsibility

Please read over the form and note the box (es) checked. Please verify by initialing. Patient/Parent/Legal Guardian signature is required at the bottom.

Ultimate Responsibility

❑ I understand that it is the responsibility of the insured or parent/legal guardian for minors to be ultimately responsible for any and all related charges incurred as a result of treatment. By signing this form, I will be fully responsible for any financial obligations associated with JSAPA _____
Initial

Medicaid and Medicare Authorization

❑ I authorize any holder of medical or other information about me or my child/ward in the case of a minor to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicaid or Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits whether to myself or the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment or the treatment of my child/ward. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicaid or Medicare assignment of benefits also apply. _____
Initial

Insurance Authorization (Non-Medicare or Medicaid)

❑ I authorize the release of any medical information necessary to process any of my medical insurance claims. I authorize my insurance carrier to make payment directly to Robert Cywes, M.D., Ph.D. and/or JSAPA and allow my signature to remain on file for future insurance filing for services rendered. _____
Initial

Reasonable and Necessary Services

❑ Your insurance carrier may only pay for services that it determines to be “reasonable and necessary”. They may deny payment for the following services:

Adjustable Gastric Banding Procedure and Aftercare

Beneficiary’s Acknowledgement and Agreement to Pay:

I have been notified by the practice that they cannot guarantee payment by my insurance company. I agree to be responsible for payment and will not hold my insurance carrier responsible. I understand that the practice will work with me and the insurance company in the event any of my claims are denied. _____ Initial

Insurance Verification

❑ I understand that my/my child/ward's insurance was not able to be pre-verified. In the event they should not pay for any reason, I am responsible for the billed amount and agree to pay the account in full. _____
Initial

_____ _____
Patient /Legal Guardian Signature Date

Revised 02/2017