Patient Name: _____

Insurance Assignment: I request that payment of authorized Medicare/other insurance benefits be made either to me or on my behalf to Chester Medical Associates for any services furnished me by Chester Medical Associates. I authorize 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 or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand that this release may include sensitive information such as psychiatric and/or alcoholism treatment, HIV and drug testing information. If item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/other insurance company assigned cases Chester Medical Associates agrees to accept the charge determination of the Medicare/other insurance company as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/other insurance company. I will be financially responsible for any non-covered, patient-billable services. A service charge will be assessed on any past due accounts.

Patient's Signature _____ Date _____

HIPPA Notice of Privacy Practices

I hereby acknowledge receipt of the HIPPA Notice of Privacy Practices from Chester Medical Associates.

Patient's Signature _____ Date _____

CREDIT CARD PAYMENT INFORMATION:

Patient's Name(s): _____

☐ Master Card ☐ Visa ☐ Discover

Card #: _____

Security Code (CVV): _____

Expiration Date: _____ Billing Zip Code: _____

_____

Authorized Signature Date