**ASSIGNMENT OF BENEFITS**

**MEDICARE**

Are you or your spouse currently employed? \_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_ No

If YES, do you know if your Medicare is \_\_\_\_ Primary \_\_\_\_ Secondary \_\_\_\_ Unknown

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request payment of authorized Medicare benefits to be made either to me or on my behalf to the ROCHESTER MEDICAL CENTER and/or physician associated with the above named Center for any services furnished to me by them. 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 for related services.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMERCIAL**

I hereby authorize payment directly to the ROCHESTER MEDICAL CENTER and/or any physician associated with the above named Center for any services furnished to me by them. I authorize said Center and/or physician to release any information acquired in the course of my treatment necessary to determine those benefits payable for related services.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT (if patient is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PAYMENT POLICY**

The policy of the ROCHESTER MEDICAL CENTER is that payment is made at the time of services for all office visits and physician consultations. Patient and/or guarantor are responsible for all deductibles, co-payments, and non-covered services or procedures performed by the ROCHESTER MEDICAL CENTER.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_