ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Mashantucket Pequot Tribal Health Services for the services rendered to me or my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

MEDICARE/MEDICAID/CHAMPUS

I certify that the information given by me in applying for payment under these programs is correct. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Mashantucket Pequot Tribal Health Services.

RELEASE OF INFORMATION:

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize Mashantucket Pequot Tribal Health Services to release any of my or my dependent's medical or personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
(If patient under age 18)