ASSIGNMENT OF BENEFITS

I _____(PRINT PATIENT NAME) HEREBY ASSIGN TO PHYSICIANS ELDERCARE, P.A. ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED FOR HEALTHCARE SERVICES PROVIDED TO ME BY PHYSICIANS ELDERCARE, P.A.

I HEREBY AUTHORIZE AND DIRECT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND MY PRIVATE INSURANCE PROVIDERS TO ISSUE PAYMENTS OF BENEFITS DIRECTLY TO PHYSICIANS ELDERCARE, P.A. FOR ANY SERVICES RENDERED TO ME BY PHYSICIAN ELDERCARE, P.A.

I HEREBY AUTHORIZE ANY MEDICAL INFORMATION ABOUT ME OR ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES TO BE RELEASED BY PHYSICIANS ELDERCARE, P.A. TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND MY PRIVATE INSURANCE PROVIDERS.

_____
Signature of Patient or Representative

_____
Print Name of Representative (if applicable)

Date: _____

Please describe the Representative's authority to act on behalf of Patient (initial one):

( ) The representative is the guardian of the patient, who has been adjudicated incompetent.

( ) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to Physicians Eldercare, PA personnel.

Physicians Eldercare, P.A. requests two witnesses' signature to be obtained when a patient cannot sign or uses an "X" as a signature. Each witness hereby verifies that the patient understands the above and agrees to the content.

Witness Date Witness Date

CONSENT TO TREAT

I _____(PRINT NAME) HEREBY AUTHORIZE PHYSICIANS ELDERCARE, P.A. OR ITS ASSIGNEES TO PROVIDE MEDICAL TREATMENT TO ME AS THEY DEEM MEDICALLY NECESSARY BASED ON MY MEDICAL CONDITION.

_____
Signature of Patient or Representative

_____
Print Name of Representative (if applicable)

Date: _____

Please describe the Representative's authority to act on behalf of Patient (initial one):

( ) The representative is the guardian of the patient, who has been adjudicated incompetent.
( ) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to Physicians Eldercare, PA personnel.

Physicians Eldercare, P.A. requests two witnesses' signature to be obtained when a patient cannot sign or uses an "X" as a signature. Each witness hereby verifies that the patient understands the above and agrees to the content.

Witness Date Witness Date