3700 US Highway South
St. Augustine, FL 32086
Phone: 904-794-2464
Fax: 904-824-5551

215 Highway 17 South
East Palatka, FL 32131
Phone: 386-227-5121

385 Palm Coast Parkway SW, Unit 1
Palm Coast, FL 32137
Phone: 386-445-4700
Fax: 386-446-4407

GOAR DE LAMERENS, M.D.

Insurance Information

Medicare

Medicare Number: ______________________________ Effective Date: ______________________________

Medicaid

Medicaid Number: ______________________________ Effective Date: ______________________________

Private Insurance Company (please provide a copy of your card)

Primary Insurance Company: ____

Name on Policy: ________________________ Date of Birth: _______________ SSN: __________________

Insurance Company Address: ____

Policy Number: ___________________ Group Number: ____________________ Effec. Date: ___________

Secondary Insurance Company: ____

Name on Policy: ________________________ Date of Birth: _______________ SSN: __________________

Insurance Company Address: ____

Policy Number: ___________________ Group Number: ____________________ Effec. Date: ___________

Is this visit regarding an accident?

Date of Injury: _____________ Work Related: Yes _____ No _____ Auto Accident: Yes _____ No ______

Does your insurance company need to be notified of any surgeries or admission? Yes _____ No ______

AUTHORIZATION TO TREAT/INSURANCE PROCESSING AUTHORIZATION/ASSIGNMENT OF BENEFITS

I ___________________________ HEREBY AUTHORIZE TREATMENT AND SERVICES AS RENDERED BY *ASSOCIATES IN INTERNAL MEDICINE PA/Dr. Goar deLamerens,* AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMIN, HEALTH CARE ADMIN, THEIR INTERMEDIARIES, OR ANY OTHER INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS OR ANY MEDICARE INSURANCE CLAIM.

I REQUEST PAYMENT OF ANY MEDICAL INSURANCE BENEFITS OTHERWISE PAYABLE TO MYSELF OR ANOTHER POLICYHOLDER TO *ASSOCIATES IN INTERNAL MEDICINE PA/Dr. Goar deLamerens, M.D.* OR THE PARTY WHO ACCEPTS ASSIGNMENT. I ALSO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ABOUT ME AS NECESSARY FOR THE PURPOSE OF PATIENT REFERRAL AND OR CONCURRENT CARE. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES CLASSIFIED AS NON-COVERED BY MEDICARE OR SAID INSURANCE COVERAGE WITH OR WITHOUT ADVANCE NOTICE. I UNDERSTAND THAT I WILL BE INFORMED OF ANY SUCH CHARGES ON THE DAY OF SERVICE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

Patient Signature ____ **Date** _______________________

Guardian Signature____ **Date** _______________________

Relationship to Patient __________________________________