Plaza Home Care Pharmacy

Patient: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

1. MEDICAL INFORMATION AUTHORIZATION: I hereby authorize my hospital, physician, home health agency and laboratory to furnish to an agent of PHARMACY and all records pertaining to my medical history, service rendered or treatment as they relate to my therapy.
2. RELEASE OF MEDICAL RECORDS TO INSURANCE CARRIER: I hereby authorize PHARMACY to furnish to my insurance carrier(s), its agent(s), accreditation and licensing organizations and other related health care providers any medical information concerning medical history, services rendered or treatment needed to process claims and coordinate services.
3. ASSIGNMENT OF INSURANCE BENEFITS: I authorize direct payment to PHARMACY of any insurance benefits otherwise payable to me for provided products or services. I also authorize my insurance company(ies) to furnish to any agent of PHARMACY, any and all information pertaining to my insurance benefits.
4. AUTHORIZATIONS TO APPEAL FOR ANY CLAIMS PROVIDED BY PLAZA HOME CARE PHARMACY: I authorize Plaza Home Care Pharmacy to file appeals to the insurance carriers regarding the claims provided by Plaza Home Care Pharmacy.

In the event that my carrier or any person or agency which may pay for or reimburse any medical care expenses does not accept "assignment of benefits," I understand that all correspondence any payment for PHARMACY may be sent directly to me. I agree that when such payments are received, I will send them to PHARMACY for payment of my bill. I understand that I can make payment for services either by personal check or by endorsing the payment I receive in writing "pay to the order of PHARMACY" and my signature.

I further understand that should this amount become delinquent and it becomes necessary for the account to be rendered or be referred to attorney or collection agency or suit, I as the designated responsible party, shall pay the reasonable attorney fees and collection expenses.

I understand that I may call if I should have questions regarding my insurance benefits or account. This reimbursement department may be reached at: (626) 585-8521

NOTE: the undersigned certifies that he/she has read the foregoing and received a copy thereof. The undersigned also certifies that he/she is the patient, or is duly authorized by the patient's general agent to execute the above items.

Patient: _____ Date: _____

Witness: _____ Date: _____

Patient's Agent or Representative: Patient or Guardian: Date: _____

Relationship: _____

Fax completed form to (626) 585-8031

900 S Arroyo Pkwy. Unit #150 Pasadena, CA 91105

Tel: (626) 585-8521 Fax: (626) 585-8031 1 800-RX Plaza