



FORM 2

PHILADELPHIA HEALTH ASSOCIATES  
ADULT MEDICINE, P.C.

[www.phaadultmedicine.com](http://www.phaadultmedicine.com)

Shahana N. Karim, MD  
Jon A. Shapiro, MD  
Wilbert R. Warren, MD, FACP

1740 South Street, Suite 300  
Philadelphia, PA 19146  
Fax: 215-732-1812  
TEL: 215-732-0876

### Insurance & Payment Release Form

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

#### The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. It is my responsibility to pay the deductible and coinsurance, and any other balances not paid by my insurance. PHA - Adult Medicine will assist in receiving reimbursement but I am responsible for my bill. Where applicable, I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to PHA - Adult Medicine. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original.

#### The Medicare Fee-For-Service Patient

I request payment of authorized Medicare benefits to be made to me or on my behalf to PHA - Adult Medicine for any services furnished me by my provider. 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 benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original.

**I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

If the above signature is not the patient's signature, please complete below:

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_

For Office Only:

Witness \_\_\_\_\_ Date \_\_\_\_\_