LANCASTER
NEUROSCIENCE
& SPINE ASSOCIATES

ASSIGNMENT OF MEDICAL BENEFITS OTHER THAN MEDICARE

I hereby assign transfer and set over to Lancaster Neuroscience & Spine Associates (LNSA) and The Center for Spine Care (CSC) all of my rights, title and interest to my medical reimbursement benefits under my insurance policy or Worker's Compensation carrier for any services furnished me by them (LNSA/CSC).
I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ DATE_____
Signature of patient or authorized representative

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lancaster NeuroScience & Spine Associates and The Center for Spine Care for any services furnished me by physician or supplier. 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 these benefits or the benefits payable for related services.

_____ DATE_____
Signature of patient or authorized representative

COMMUNICATIONS AUTHORIZATION

Lancaster NeuroScience & Spine Associates and The Center for Spine Care, its physicians and staff, are authorized to use telephone message systems to aid communications with me, or my authorized representative, regarding my treatment, appointments, financial arrangements, and in response to any request I have initiated.

_____ DATE_____
Signature of patient or authorized representative

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Lancaster NeuroScience & Spine Associates and The Center for Spine Care, its physicians and staff, are authorized to share information and provide copies of my entire medical records, including all written and oral reports, substantive evaluations of progress, history, diagnosis, prognosis, course of treatment, reports, and attendance and compliance with respect to all care or treatment, including all confidential HIV and AIDS related information, mental health records, drug and alcohol, abuse treatment records, sexual assault and sexual abuse counseling records to my insurance companies, doctors, treating facilities, and my employer in the case of Worker's Compensation, and the following persons:
CHECK ALL THAT APPLY:

( ) Spouse-Name_____ ( ) Parents, if over 18-Name(s)_____

( ) Children-Name(s)_____

_____

( ) Authorized Resresentative-Name_____

( ) Other-Name(s)_____

_____ DATE_____
Signature of patient or authorized representative

I have read and understand the above assignments and authorizations to use/disclose health information about the named patient as described. These assignments/authorizations remain in effect until revoked by me in writing.

A copy of any or all above signatures is as valid as the original.