

DRS BEAMER, CARLON & CRAIGEN, S.C.

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AUTHORIZATIONS, ASSIGNMENTS AND RELEASES

AUTHORIZATION OF CARE

I hereby authorize Drs. Beamer, Carlon, and Craigen, M.D, S.C. physicians and staff to examine me, to perform tests and procedures as they feel In their judgment are reasonable and necessary in the diagnosis and treatment of my case. No test or procedure will be performed without informed consent and prior approval by me. I acknowledge that no guarantees will be made to me as to the result of treatments and examinations done.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Drs. Beamer, Carlon, and Craigen to furnish to my health insurance company and/or the insurance company’s review agency, or other third party payors of their designated agents, all the information the above named entities may request concerning treatment for myself and my dependents, including medical records.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

I hereby authorize Drs. Beamer, Carlon, and Craigen, M.D., the medical and for surgical benefits to which I or my dependents are entitled under my health insurance plan, I guarantee payment in full for all amounts not covered by the assigned third party payor(s).

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT

I agree that if the amount of any insurance benefits due to me is insufficient to cover the professional fees of my care, that I will be responsible for the payment of the difference, including any deductibles and co-payments. If insurance coverage is insufficient, denied or otherwise unavailable, I agree to pay for all the charges not covered by the insurance

I understand that if I am insured under a managed care plan which is contracted with Drs. Beamer, Carlon, and Craigen, I will be responsible for payment of all co-pays, deductibles, and non-covered services.

ORIGINAL ASSIGNMENTS~ AUTHORIZATIONS AND REALEASES ON FILE

I permit a copy of the above assignments, authorizations, and releases to be used in place of the originals which have been filed in the office. I have read this form and understand its contents.

Print name of patient

Signature of patient or personal representative

____/____/____
Date (Month/Day/Year)

_____)
Relationship of signer if not patient

Signature of witness

Michele F. Carlon, M.D.
Board Certified in Internal Medicine

Emily K. Beamer, M.D.,
Board Certified in Internal Medicine & Pediatrics

Rhea Craigen, M.D.,
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