**1898 W. Hillsboro Blvd, Suite H**
**Deerfield Beach, FL 33442**
**Phone (954) 571-9392 Fax: (954) 571-6788**

## Authorization to Release Medical Records to RegenQuest

Patient Name: ______________________________________________

Date of Birth: __________________ Social Security Number (Last 4 digits only): ______________

### RECORDS TO BE RELEASED

**For purposes of my evaluation and treatment, RegenQuest will require the following information from my medical records:**

All records relating to my condition/diagnosis of ________________________________________

__________________________________________________________________________,
including without limitation, history and physical, office visit notes, physician consults, radiology and laboratory reports, and reports of other consultations or tests related to my condition.

### AUTHORIZATION

**I hereby authorize the following provider to release all of my protected health information referenced above to RegenQuest:**

Physician/Hospital/Facility: ______________________________________________

Street Address: ______________________________________________________

Phone #: ________________________ Fax #: ______________________________

This authorization will remain in effect until I am discharged as a patient of RegenQuest. I understand that I may withdraw this authorization at any time by giving written notice to the Clinic Administrator at RegenQuest. A photocopy of this authorization is as valid as the original.

Patient Signature: ____________________________________ Date:______________________

If legal guardian, state relationship: __________________________________________

**ASSIGNMENT OF BENEFITS**
**AUTHORIZATION TO RELEASE INFORMATION**
**FINANCIAL RESPONSIBILITY**

**Assignment of Benefits**
I hereby irrevocably assign and transfer directly to REGENQUEST and/or its providers (collectively REGENQUEST), as my designated authorized representative, all right, title and interest in and to all medical benefits and/or insurance reimbursement for all services provided by REGENQUEST, which are provided in any and all insurance policies and health benefit plans under which I am entitled to services or entitled to recover, regardless of the network participation status of REGENQUEST. I further assign to REGENQUEST, as my designated authorized representative, all of my rights to pursue administrative appeals or litigation against such insurance carriers, health plans and their agents to obtain payment for services rendered by REGENQUEST, and the right to pursue all other claims, including without limitation ERISA claims, against such insurance carriers, health plans and their agents. I hereby authorize and direct my insurance carriers, including Medicare, private insurance and any other health/medical plan, and their agents, to issue payment check(s) directly to REGENQUEST for services rendered to myself and/or my dependents. **I understand that I am financially responsible to REGENQUEST for all charges for services, including any amount not paid by my insurance or health plan.**

**Authorization to Release Information**
I hereby authorize REGENQUEST to: (1) release all information necessary to process claims to my insurance carrier, health plans or their agents; (2) process claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process claims for the period of my lifetime. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to REGENQUEST any and all plan documents, summary benefit description, insurance policies, and/or settlement information upon written request from REGENQUEST or its attorneys in order to claim such medical benefits or pursue any assigned claims. This authorization to release information will remain in effect until revoked by me in writing.

**Financial Responsibility**
All services rendered by REGENQUEST are charged to the patient and are due at the time services are provided, unless other arrangements regarding the date of payment have been made in advance with our financial counselor. Claim forms will be completed to help expedite insurance/health plan payments. **However, the patient is responsible for all charges for services provided by REGENQUEST, regardless of insurance coverage. I understand that REGENQUEST is not required to pursue payment from any insurance carrier, health plan or their agent. Should the account be referred to an attorney or agency for collection, I agree to pay reasonable attorney's fees and collection expenses whether suit is filed or not.** Delinquent accounts and amounts (those not paid within 30 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law.
I have requested medical services from REGENQUEST on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred for the services provided. I further understand that fees are due and payable on the date that

services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the REGENQUEST statement.

A photocopy of this document is to be considered as valid as the original.

By my signature below, I acknowledge that I have read, understand and agree to all of the provisions of this document.

______________________________

**Print** Name of Patient

______________________________

**Print** Name of Responsible Party/Plan Participant
(if different than patient)

______________________________

**Signature** of Patient (if not a minor)

______________________________

**Signature** of Responsible Party/Plan Participant

______________________________

**Signature** of Witness

______________

Date