LightBridge
MEDICAL ASSOCIATES

CONSENT FOR TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMTION FOR BILLING PURPOSES

Assignment of Insurance Benefits: I, the undersigned, authorize direct payments to Lightbridge Medical Associates for all services rendered to me by Lightbridge Medical Associates. I understand that I am financially responsible for any and all amounts not covered by my insurance, including copays, deductibles, share of costs, patient responsibilities and any other applicable amounts. I also authorize you to release to my insurance company or their agent information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Authorization for Release of Information: I authorize Lightbridge Medical Associates to release any medical or other information to my insurer or their agent concerning the treatment and services provided to me by Lightbridge Medical Associates.

If Medicare: I request that payment of authorized Medicare benefits be made on my behalf to LightBridge Medical Associates for any services furnished to me by their medical practitioners. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Patient Representative Name: _____ **Date:** _____

Patient Representative Signature: _____

Consent for Treatment: I consent to receive treatment from LightBridge Medical Associates, a California Professional Corporation. Specifically:

- I understand:
  - The LightBridge Medical Associates clinician does not replace my Primary Care Physician, specialists, or other caregivers but works collaboratively with them to coordinate my medical care.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Patient Representative Name: _____ **Date:** _____

Patient Representative Signature: _____