



*Personalized Care with Exceptional Results*

## **Signature On File For Medicare Billing/ Statement of Responsibility**

I certify that the information given by me in applying for payment under Title XVIII (Medicare) is, to the best of my knowledge, true and correct. I hereby authorize release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for institutional or physician services to the physician or organization furnishing the services or authorize such organization or physician to submit a claim to Medicare for payment on my behalf. This also applies to all ancillary services which might be ordered on my behalf by River Garden professional/ clinical staff and provided by another medical supplier/ contractor.

Certain services, such as stat fees, duplication of X-rays and medical records are usually non-covered by insurers. I understand that I could possible be financial responsible for these types of services if they should apply.

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*(Client's Printed Name)*

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*(Date)*

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*(Client or health care surrogate's signature)*

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*(Date)*