

Insurance Release Form/Advance Beneficiary Notice (Revised 10/15/17)

Paul Wexler, M.D./GENASSIST™, Inc.
8200 E Belleview Ave Suite 410C Greenwood Village, CO 80111
(303) 694-4665, (303) 694-3473 – fax

Patient Name _____ Date of Birth _____

Primary Care Physician _____

Reason For Today's Exam: _____
(e.g. ultrasound, pap smear, gyn exam etc.)

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PLEASE READ & SIGN THE FOLLOWING RELEASE FORM
(This is required by your insurance)

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I hereby authorize GENASSIST™/Paul Wexler, M.D. to release to:

(Insurance Company)

any information including the diagnosis and records on myself. I also authorize and request that this insurance company pay directly to the above provider of my services the amount due for my care.

I understand that GENASSIST™/Paul Wexler, M.D do Not bill secondary insurance. If I want an insurance claim in order to bill my secondary insurance I can contact the billing office.

If I choose to be Self Pay for today's visit, I will receive a completed insurance claim form.

I understand that if I am here for a visit without a specific problem or diagnosis the insurance company may not pay for my visit today. The Annual GYN Exam is billed with Procedure Code 99394 (Ages 12-17 yrs), 99395 (Ages 18-39 yrs), 99396 (Ages 40-64 yrs) & 99397 (Age 65+ yrs) with diagnosis Z01.419.

Even if I have insurance, I understand that I am responsible for the entire cost of today's exam and will be billed accordingly.

I understand that if my insurance requires me to have a referral for my visit and I do not have one, I will be responsible for all charges.

A service charge will be applied at a rate of 1.5% per months to balances greater than 90 days past due. In case of default payment, I agree to pay any and all costs of collecting this account including but not limited to, attorney fees and court costs.

Please acknowledge that you were informed of this by signing below, and we will keep this in your medical record.

_____	_____
Patient Printed Name	Date
_____	_____
Patient Signature	Date