OAK PARK MEDICAL CLINIC
1301 WHITE DR
BATESVILLE, AR 72501
870-793-6887

INSURANCE RELEASE

I hereby authorize Dr. Lackey Moody or Heidi Machen, APN of Oak Park Medical Clinic to apply for benefits on my behalf for covered services rendered by Dr. Lackey Moody or Heidi Machen, APN or by his/her order. I request that payment from my insurance company be made directly to DR. Lackey Moody or Heidi Machen, APN at Oak Park Medical Clinic. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at anytime in writing.

Name: _____Date: _____

Medicare Patients Only

Name of beneficiary: _____

Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Dr.Lackey Moody or Heidi Machen, APN at Oak Park Medical Clinic for any service furnished to me by my physician. I authorize any holder of medical information about me to release to Oak Park Medical Clinic any information needed to determine these benefits or the benefits payable for related services.

Signature of patient or authorized representative: _____

Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Oak Park Medical Clinic, P.A.'s Notice of Privacy Practices.

Signature of Patient: _____ Date: _____