PATIENT AUTHORIZATION FORM

PATIENT NAME: _____

MEDICARE / INSURANCE LIFETIME AUTHORIZATION:

I request that payment of authorized Medicare / Insurance benefits be paid directly to Dr. Tanuja T. Vedere. I authorize any holder of medical or other information about me to release to healthcare financing administration and its agents, any information needed to determine these benefits for related services.

INITIALS: _____

H.M.O. DISCLAIMER:

I certify that I am not enrolled in any health maintenance organization (H.M.O.). Subsequent rejection of a claim as a result of this consultation, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

INITIALS: _____

Payment is due at the time of your visit unless prior arrangements have been made with our business office. All questions regarding insurance or fees should be asked prior to services being rendered. I hereby authorize the release of any medical information necessary to process my insurance. I hereby authorize payment of medical and/or surgical benefits to Dr. Tanuja T. Vedere for any services furnished to me by this physician when insurance is applicable. I understand that I am financially responsible for charges regardless of my coverage. I further agree that in the event that my account must be refereed to a collection agency or an attorney for court collection, I will be held responsible for all costs resulting from such action. A photocopy of this authorization should be considered as effective and as valid as the original.

PATIENT'S SIGNATURE: _____

WITNESS: _____

DATE: _____