

Patient Name : _____

ASSIGNMENT OF BENEFITS & AUTHORIZATION OF RELEASE OF INFORMATION

I (the patient as noted above) hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Private insurance and any other Health/Medical plan to issue payment checks directly to Tarek M. Sallam M.D. for any medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any, I understand that I am RESPONSIBLE for any amount not covered by my insurance.

I hereby authorize Tarek M. Sallam M.D. To furnish and/or release any information necessary to any other doctors and all relevant insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, and to allow a photocopy of my signature to be used to process my insurance claim for a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Tarek M. Sallam M.D. On behalf of myself and/or by the referral of a referring physician, and understand that by making this request, I become fully FINACIALLY RESPONSIBLE for any and all charges incurred in the course of the treatment authorized. I further understand that fees (deductibles, co-pay), are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon services rendered. A photocopy of this assignment is to be considered as valid as the original.

Attestation:

I have had the opportunity to review the Practice's Notice of Privacy (HIPAA), patient's rights & responsibilities policy, patient safety statement information (located in the waiting room).

Patient / Responsible Party – Signature: _____ Date: _____

Responsible Party (if not patient) – Print Full Name: _____

* As per CMS guidelines