

## AUTHORIZATION

I, THE UNDERSIGNED HEREBY AUTHORIZE PAYMENT DIRECTLY TO ANDREW B. CHERTOFF, M.D., P.C. OF HEALTH INSURANCE BENEFITS, OTHERWISE, PAYABLE TO ME UNDER THE TERMS OF MY HEALTH INSURANCE POLICY.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FEES INCURRED BY ME AND/OR MINOR PATIENT. I FURTHER UNDERSTAND THAT PAYMENT TO SAID DOCTOR IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGMENT OR VERDICT BY WHICH THE PATIENT MAY EVENTUALLY RECOVER HEALTH INSURANCE BENEFITS.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY.

I HEREBY AGREE THAT I, THE UNDERSIGNED, SHALL BE LIABLE FOR ANY ATTORNEY'S FEE AND/OR COLLECTION COSTS INCURRED BY ANDREW B. CHERTOFF, M.D., P.C. IN THE EVENT THAT FEES FOR SERVICES RENDERED TO ME ARE PLACED WITH AN ATTORNEY OR OTHER THIRD PARTY.

I HEREBY AUTHORIZE MEDICAL TREATMENT BY ANDREW B. CHERTOFF, M.D., P.C. TO THIS PATIENT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR RELATED INFORMATION NECESSARY TO PROCESS THIS CLAIM. I UNDERSTAND PAYMENT IN FULL, REGARDLESS OF INSURANCE STATUS, IS MY RESPONSIBILITY, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTHCARE PRACTITIONER, HOSPITAL OR MEDICAL CARE FACILITY TO PROVIDE ALL INFORMATION OF THE MEDICAL HISTORY OF THE PATIENT'S NAME BELOW TO ANDREW B. CHERTOFF, M.D., P.C.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BY MADE TO ME OR ON MY BEHALF TO (PROVIDER NAME) FOR ANY SERVICES FURNISHED ME. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTER FOR MEDICARE & MEDICAID SERVICES (CMS) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
(If patient is under 18, must be signed by parent or guardian)