Kaufman & Zinsmeister, M.D., P.A.

Patient Name_____Account #_____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize KAUFMAN & ZINSMEISTER, M.D., P.A. to apply for benefits for covered services on my behalf from my insurance carrier: _____.

I further authorize payment be made directly to KAUFMAN & ZINSMEISTER, M.D., P.A. (or in case of Medicare Part B benefits, to myself or the party who accepts assignment) of the medical benefits otherwise payable to me for services rendered by Steven K. Kaufman, M.D. and Bruce W. Zinsmeister, M.D.

X_____ _____
Signature of Policy Holder/Patient Date

FINANCIAL AGREEMENT

I assume financial responsibility for and agree to make payment in full to KAUFMAN & ZINSMEISTER, M.D., P.A. for all charges for services rendered to the above named patient not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements to be made with the billing office. I certify that the financial information given is true, accurate and complete to the best of my knowledge. I further authorize KAUFMAN & ZINSMEISTER, M.D., P.A. to investigate any and all financial information given concerning this or other claims filed on my behalf.

X_____ _____
Signature of Patient Date

CONSENT TO THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to the disclosure of protected health information for treatment, payment, and healthcare operations. Such information may be required by my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administrator and the Centers for Medicare and Medicaid Services—CMS) or its designated agent in order to determine benefits to which I may be entitled; or to designated agents of KAUFMAN & ZINSMEISTER, M.D., P.A. Refer to the Notice of Privacy Practices for a more specific description of other uses and disclosures of protected health information. I permit a copy of this consent to be used in place of the original. This consent may be revoked either by me or the above carrier at any time in writing, except to the extent that KAUFMAN & ZINSMEISTER, M.D., P.A. has already acted upon consent.

X_____ _____
Signature of Patient Date

MISSED APPOINTMENT POLICY

KAUFMAN & ZINSMEISTER, M.D., P.A requests 24-hours' notice of cancellation of an appointment. A $50 fee will be charged for a missed appointment without notice of cancellation. I have read and acknowledge the aforementioned policy.

X_____ _____
Signature of Patient Date