PATIENT AUTHORIZATION FORM

I hereby authorize Dr. Michael Lupovici to examine me and address my gastroenterology issues during this visit and all subsequent visits. If I am not covered by insurance, I agree to pay for the office visit at the time of my appointment. If my insurance carrier requires a referral and I do not present a valid copy to the front desk, I assume personal responsibility for all charges not covered by insurance.

SIGNATURE **DATE**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE **DATE**

If you have a supplemental policy to which Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. Please read and sign the following statement:

I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE **DATE**