

Parveen S. Vahora, MD PA

PERMISSION TO TREAT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Parveen S. Vahora, MD PA deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by **Parveen S. Vahora, MD PA**. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits related to services.

I hereby authorize **Parveen S. Vahora, MD PA** to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) Insurance Carrier(s)/Medicare to make payments directly to **Parveen S. Vahora, MD PA** for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any changes incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers may not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: _____ Date: _____

DESIGNATED RELATIVE

I authorize Discussion on My General Medical Condition and Diagnosis (including treatment, payment and health care operations) with: Spouse Children Other _____

Please list the family members or significant others, if any, whom We May Inform about Your Medical Condition, and in Case of an Emergency:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Messages May Be Left on My Answering Machine Regarding My Health & Appointment Made: Yes No.

Signature: _____ Date: _____

PRIVACY NOTICE

I have received a copy the HIIPA Privacy Notice.

Signature: _____ Date: _____

Patients Name (print): _____ SS#: _____

Witness: _____ Relationship: _____