SUPPLIER/PROVIDER OR GROUP SIGNATURE PAGE

"ONE TIME AUTHORIZATION AGREEMENT"
STATEMENT TO PERMIT PAYMENT OF MEDICARE
BENEFITS TO PROVIDERS, PHYSICIANS AND PATIENTS
This section applicable only if patient is a Medicare Recipient

NAME OF BENEFICIARY _____ HIC CLAIM NUMBER _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents and any information needed to determine these benefits for related services.

_____Payment to Patient ___X__Payment to Provider

Provider Signature: _____ Date:_____

Provider/Supplier Name: Edward A. Tashjian, M.D., P.C. Date:_____

***Acknowledgement of receipt of our Privacy Policy-**
By signing this form I acknowledge that I have received a copy of the Privacy Policy for Edward Tashjian M.D. and understand its contents.

***Patient Consent to Treat -** By signing this form I consent to diagnostic testing and or Physiatric evaluation and disclosures of my information that is deemed necessary in order to provide me with the proper treatment.

***Assignment of Benefits-** By signing this form I understand that my insurance company will pay the physician directly for my service and if there is a clause in the contract that pays me (the patient) directly, I understand I am liable for this claim.

***Records Release Authorization:** I hereby authorize & request you to release all records in your possession concerning myself to: _____
Address:_____
Phone#- _____Fax#_____

Patient Signature: _____ Date: _____
Witness Signature: _____

*Patient refused to sign form for the following reasons: _____

_____