

**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 Physiatic 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: \_\_\_\_\_

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