PERSAUD MEDICAL, PLLC

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AUTHORIZATIONS & AGREEMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

In consideration of services and care rendered for today's visit and all future visits, I agree that I am responsible for any and all charges billed by **Persaud Medical, PLLC** with respect to such services and care. If my insurance is one of the plans with which **Persaud Medical, PLLC** participates, I understand that my insurance carrier will be billed directly and will accept assignment on covered services, but I agree to pay copays, coinsurance, DEDUCTIBLES, non-covered services, not meeting medical criteria. I agree to pay all amounts not covered by insurance immediately. If **Persaud Medical, PLLC** incurs a collection agency or legal expenses in attempting to obtain payment on my account, I agree to be responsible for these expenses in their entirety.

2. RELEASE OF INFORMATION FOR PAYMENT OF CLAIMS

I authorize, **Persaud Medical, PLLC**, to release any and all information (including, if applicable, information relating to mental illness and or AIDS/ARC/HIV) needed exclusively for the payment of professional charges and to permit representatives of these responsible for such payment the examination any copy of all records relating to the care and treatment received, if requested.

3. MEDICARE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS (APPLICABLE TO MEDICARE PATIENTS ONLY)

I certify that the information given by me in applying for payments under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to **Dr. Persaud**. I understand that if I have selected a Medicare managed care plan **Dr. Persaud** may not participate with this plan, and I will be billed for any balances that the plan does not pay.

4. NO-SHOW FEE

I understand that **Dr. Persuad** reserves the right to charge a "No-Show Fee" of $25.00 for missed appointments and appointments that are cancelled with less than 24 hours notice.

I HAVE READ, UNDERSTAND, AND AGREE WITH THE ABOVE ITEMS.

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Signature of Patient or Authorized Representative   Date

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Relationship to Patient   2012