Michael S. Fleischer, M.D., F.A.C.O.G.
Obstetrics ♦ Gynecology ♦ Infertility

INSURANCE AUTHORIZATION

I, _____, REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO THE ABOVE NAMED PHYSICIAN ON MY BEHALF, FOR ANY SERVICES PROVIDED TO ME.

I AUTHORIZE ANY HOLDER OF MEDICAL AND OTHER INFORMANTION ABOUT ME TO BE RELEASED TO MEDICARE AND ITS AGENTS, ANY PRIVATE OR COMMERCIAL INSURANCE COMPANY, THIRD PAYER, STATE OR GOVERNMENTAL MEDICAL ASSISTANCE AGENCY, OR PRIVATE PAYER RESPONSIBLE FOR PAYING SUCH BENEFITS FOR DETERMINATION AND RESPONSIBILITY OF REIMBURSEMENT FOR ALL SERVICES RENDERED TO ME.

I AGREE TO PAY FOR ALL NON-COVERED CHARGES FOR SERVICES TO ME BY THE ABOVED NAMED PHYSICIAN .

I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

**********CO-PAYMENTS ARE TO BE PAID AT THE TIME OF SERVICE*********

*******THERE WILL BE A $30.00 CHARGE FOR ALL RETURNED CHECKS*******

ALL "PATIENT RESPONSIBILITY" BALANCES ARE TO BE PAID IN FULL WITHIN 90 DAYS OR ACCOUNT WILL BE SUBJECT TO COLLECTIONS.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THESE OFFICE POLICIES AND AGREE TO MAKE PAYMENT IN FULL OR ARRANGE A PAYMENT PLAN PRIOR TO SERVICES RENDERED.

_____ _____

PATIENT'S OR REPRESENTATIVE SIGNATURE DATE