

RICHARD S. OBEDIAN, M.D., F.A.A.O.S, PLLC

81 North Broadway
Hicksville, New York 11801

Phone: (516) 933-4350
Fax: (516) 933-4352



AUTHORIZATION/SIGNATURE ON FILE I authorize the use of this form for all my insurance submissions, release of information to all my insurance companies or adjusters involved in this case. I authorize payment directly to Richard S. Obedian, M.D., at the address designated by him. I permit a copy of this authorization to be used in place of an original. I authorize Richard S. Obedian, M.D. to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize Richard S. Obedian to act as my agent in helping me obtain payment from all of my Insurance Companies, this is a direct assignment of my rights and benefits under the above policy.

FINANCIAL POLICY In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

YOUR INSURANCE We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office collect the co-payment when you arrive for your appointment. If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you on an unassigned basis. Your insurer will send the payment directly to you and you are responsible to sign over the check along with any EOB's that relate to your services. Patient will be responsible for the deductible and any balance from your insurance carrier. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. It is the patient's responsibility to obtain the necessary referral or authorization needed by your insurance company in order to be seen by Richard S. Obedian, M.D. If this information is not on file with the insurance carrier and you would like to be seen, then you will be responsible for all services rendered during the office visit.

PATIENT'S AUTHORIZATION SIGNATURE FORM " I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment give to me or any dependent for purposes of review, investigation or evaluation of any claim submitted by my insurance carrier. I also authorize my insurance carrier to disclose information to a hospital or health care service plan, self-insurer, or an insurer of any medical information obtained if such disclosure is necessary to allow the processing of the claim. If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit."

ACKNOWLEDGEMENT FORM: I acknowledge that the Notice of Privacy Procedures is posted in plain sight for my review in this office and I have been provided an opportunity to review it.

PATIENT RECORD OF DISCLOSURE

I wish to be contacted in the following manner (check all that apply):
 Home Tele: _____ Bs Tele: _____ Cell: _____

Signature Written Communications: Mail to home address () Mail to business address: ()

I authorize you to contact or speak to the following individuals regarding my care: _____ -

"I verify the accuracy of the above information and I authorize the release of information as provided on this form. I also authorize the assignment of benefits directly to Richard S. Obedian, M.D. I understand that I am financially responsible for the treatment rendered. I hereby authorize Richard S. Obedian, M.D. to submit a claim to the insurance carrier or its intermediaries for all covered services rendered for radiology and orthopaedic care and authorize and direct the insurance carrier or its intermediaries to issue payment check(s) directly to Richard S. Obedian, M.D."

SIGNATURE _____

DATE _____