

**M. AZHAR ALI, M.D., F.A.C.S.**

**AUTHORIZATION AND AGREEMENT OF MEDICAL TREATMENT INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY**

The undersigned hereby makes the following Acknowledgements and Agreements regarding medical treatment, insurance benefits, financial responsibility and release of information to be provided by M. Azhar Ali, M.D. or associates or assistants to the patient whose name appears below.

**CONSENT FOR EXAMINATION:** I understand that medical treatment may be necessary for the patient by M. Azhar Ali, M.D. or associates or assistants.

I understand the examination procedures will be explained to me and I shall consent to the rapid, partial or complete medical examination of the parts of my body I show to the examiner. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with the physician. I hereby release my examiner from all responsibility in connection with this examination.

**CONSENT FOR TREATMENT:** I understand that medical treatment is necessary for the patient by M. Azhar Ali M.D. or associates or assistants. I hereby authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

**INSURANCE BENEFITS:** As a courtesy to patients of M. Azhar Ali, M.D. acceptable insurance claims will be processed. I hereby authorize my insurance benefits to be paid directly to M. Azhar Ali, M.D. I am financially responsible for all office visit charges, which are payable at the time of service, all deductibles, coinsurance (copay), and non-covered and/or disallowed services by Medicare, Blue Cross Blue Shield, Medicaid, Private Insurance or collection costs, court costs and reasonable attorney fees.

**NO INSURANCE BENEFITS:** For patients with NO insurance, I acknowledge I am responsible for all charges for services and payment is expected at the time of service unless arrangements are made in advance for a payment plan. Patients are encouraged to discuss fees with the finance department of the practice prior to any major medical or surgical procedure.

**INSURANCE CHANGES:** Please be advised that it is the patient's responsibility to inform our office of any insurance or address changes promptly. In the event that the wrong insurance is billed it will be the patient's responsibility for payment.

**BLUE CARE NETWORK AND ALL HMO PLANS:** Please be advised that it is the patient's responsibility to obtain a written referral prior to all scheduled office visits.

**RELEASE OF INFORMATION:** I hereby authorize M. Azhar Ali, M.D. to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment.

I have read the above Acknowledgements and Agreements and fully understand the same.

Patient Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

My staff and I make every possible effort to provide you with comprehensive care. If you have any comments or concerns with your care, please bring it to my attention, either in person or by letter, and every effort will be made to correct the situation.