PATIENT'S AUTHORIZATION

I authorize the release of any medical information necessary to process this claim to Medicare, Medical Assistance, Blue Cross/Blue Shield of Maryland, and/or other insurance carriers named by me. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the named carrier(s) at any time in writing. I understand that the Health Care Financing Administration (HCFA) is the government Medicare Program.

_____ _____
SIGNATURE DATE

_____ _____
LEGAL GUARDIAN OR INSURANCE SUBSCRIBER (OR WITNESS) DATE

AUTHORIZATION TO PAY BENEFITS

I request that payment of authorized Medicare, Medical Assistance, Blue Cross/Blue Shield of Maryland, other insurance named by me, and/or Medigap benefits be made on my behalf to Ronald H. Schuster M.D., P.A. for any services furnished to me. I authorize a holder of medical information about me to release to the Health Care Financing Administration and its agents and/or other insurance carriers as named by me any information needed to determine those benefits or benefits payable for related services. I authorize the payment of Medigap benefits to be made to Ronald H. Schuster, M.D., P.A. for any services furnished me. I authorize any holder of medical information about me to release to _____

(Name of Medigap Insurer)

any information needed to determine these benefits or benefits payable for related services.

_____ _____
SIGNATURE DATE

_____ _____
LEGAL GUARDIAN OR INSURANCE SUBSCRIBER (OR WITNESS) DATE

AUTHORIZATION

I understand I am responsible for paying the portions due according to the contract of my insurance carrier, including all copayments and deductibles. If no insurance exists, whether due to lapse/termination of coverage or simply lack of coverage, I understand I am financially responsible for all charges for services performed for me or my legal dependent. I also understand that in the event that default of payment occurs, I will be responsible for all costs incurred by this office to secure proper payment, including but not limited to attorney fees, collection agency fees, court costs and interest.

_____ _____
NAME (PRINT) DATE

_____
SIGNATURE