

Associates in Internal Medicine, P.C
234 Central Park West, New York, NY 10024
241 East 86th Street 2D, New York, NY 10128

Patients Name: _____
(STAFF....PLEASE PRINT PATIENTS NAME CLEARLY)

Assignment of Benefits and Waiver of Liability

I hereby authorize the release of medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further authorize payment for services' to me and/or my dependents, be made directly to Associates in Internal Medicine, P.C.. I understand and agree to be financially responsible for balance(s) not covered by my insurance plan for services rendered to me by Associates in Internal Medicine, P.C. from July 1, 2000 and going forward.

(Signature of Subscriber or Spouse) (Date)

I, the undersigned have agreed to provide Associates in Internal Medicine, P.C. with the necessary referrals and documents to bill my insurance plan. If I elect to be seen without a referral, I agree to accept financial responsibility for all charges incurred. If the referral I provide is not valid for the services received, I will be responsible for all balances due to Associates in Internal Medicine, P.C. from July 1, 2000 and going forward. I accept the responsibility on behalf of myself and/or dependents.

(Signature of Subscriber or Spouse) (Date)

For Self Paying Patients Only

I hereby agree to be financially responsible for services rendered to me and/or the patient by Associates in Internal Medicine, P.C.. I understand that payment is due in full on the day services are rendered.

(Signature of Patient and/or Responsible Party) (Date)

