

M. Azhar Ali, MD FACS
Āmae Plastic & Reconstructive Surgery

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 the patient may require medical treatment 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 the patient may require medical treatment by M. Azhar Ali, M.D. or associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the 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 acknowledge that I am financially responsible for all charges for office visits, which are payable at the time of service; all deductibles, coinsurance (copay), and non-covered and/or services disallowed 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 that I am responsible for all charges for services and that 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.

RELEASE OF INFORMATION: I hereby authorize M. Azhar Ali, M.D. to release any of my information during 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's 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.