MARK D. EPSTEIN, M.D., F.A.C.S.

Claims Authorization

Blue Shield or other Insurance:
I hereby authorize any physician, heath care practitioner, hospital, or other medical or medically related facility to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to insurer.

I also authorize insurer to disclose to a hospital or health care service plan, self-insurer, or any insurer any medical information obtained if such disclosure is necessary to allow the processing of any 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.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with insurer including a reasonable time thereafter until its final consummation This authorization shall be binding upon me, my dependents, and/or heirs, executors, and administrators.

New York No-Fault Motor Vehicle Insurance Law:
In consideration of services rendered or to be rendered to the above named physician or other provider of health services of any and all first party No-Fault automobile insurance benefits to which I may otherwise be entitled for services rendered by the provider but not to exceed the provider's regular charges for such services.

In the event the provider's charges are outstanding, and I fail to file an application for benefits under the New York State No-Fault Insurance Law, I hereby authorize the provider to file such claim on my behalf so that the provider may realize payment of its charges. I understand that if the provider does not receive payment from the insurer, I am personally responsible for the payment of the provider's charges.

Authorizations

Authorization to release:

I verify the accuracy of all information provided on the Patient Information and Medical history forms. Furthermore, I hereby authorize Mark D. Epstein, M.D. to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Responsible Party's Signature ______ Patient's Signature ______ Date ______

Assignment:

I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time but not to exceed my indebtedness to said doctor. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges.

Responsible Party's Signature ______ Patient's Signature ______ Date ______