RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE
NEUROLOGY

PATIENT AUTHORIZATION FORM

MEDICARE PATIENTS: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made either to me or on my behalf to Synapse Neurological Care, PA for any services furnished me by the listed provider/supplier authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved health claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:

Date:

ASSIGNMENT OF BENEFITS

Patients with insurances please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other plans, to Synapse Neurological Care, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:

Date:

MEDICAL RECORDS FAX: I authorize Synapse Neurological Care, P.A. to transmit my medical records electronically. If they are received by another party in error, I absolve Synapse Neurological Care, P.A. of any and all liability relating to such of said records.

Signature:

Date:

I have read, understood, and agreed to financial policy for payment of professional fees. The patient is ultimately responsible for all financial fees. I further understand I am responsible for any legal fees in cost of collecting any unpaid balance.

Signature:

Date:

Synapse Neurology
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