Dr. Ariel Majjhoo **Dr. Bryant Ittiara**
1030 N. Monroe Street, Monroe, MI 48162
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Patient Authorization Signatures

Patient Name:

Last:_____First:_____ MI:_____ D.O.B.____/____/____

General Signature ~ All patients . . . Read, sign and date:

I understand that I am responsible for payment of services that are rendered to me. I understand that NeuroInterventional Pain Management will bill my insurance but that I am ultimately responsible for any balance not covered by my insurance, co-payments, deductibles, or uncovered services.

Signature:_____ Date: ____/____/____

Additionally, please complete and sign each section that applies to you:

Authorize Payment & Release of Information ~ Patients with health insurance . . . Read, sign and date:

I, the undersigned authorize payment of medical benefits to NeuroInterventional Pain Management for any services furnished me by NeuroInterventional Pain Management. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent(s) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signature:_____ Date: ____/____/____

Medicare ~ Patients with Medicare . . . Read, complete, sign and date:

I request that payment of authorized Medicare benefits be made on my behalf to NeuroInterventional Pain Management for any services furnished me by NeuroInterventional Pain Management. I authorize any holder of medical information about me to release the information to the Health Care Financing Administration and its agents in order to determine payable benefits for services rendered.

Medicare Policy Number:_____

Signature:_____ Date: ____/____/____

Medigap ~ Patients with Medigap (Medicare supplement insurance) . . . Read, complete, sign and date:

Do you receive payment from the carrier when a medical claim is filed and then you pay the provider? ☐Yes ☐No

I request that payment of authorized Medigap benefits be made on my behalf to NeuroInterventional Pain Management. I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents and my Medigap or other insurance policy that I have, any information needed to determine these benefits r the benefits payable for related services.

Medigap Carrier Name:_____ Medigap Policy Number:_____

Signature:_____ Date: ____/____/____

Verify Non-Injury ~ Patients NOT CLAIMING work, auto or slip-and-fall injury . . . Read, sign and date:

(If you ARE CLAIMING work, auto or slip-and-fall injury, please make sure you complete the form pertaining to your injury type—Do not sign this section.)

I the undersigned agree that my illness or injury is not related to a Workers' Compensation, Automobile or other "Slip and Fall" claim in which a carrier other than my health insurance should be billed.

Signature:_____ Date: ____/____/____