PRESTIGE MEDICAL GROUP

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

Patient Name: _____

MRN#:_____

Date: _____

I understand that I am financially responsible to **Lamia L. Gabal MD Inc. DBA Prestige Medical Group** for charges not covered by my insurance carrier. Please note that we **DO NOT accept Medi-Cal** and you will be personally responsible for those charges. Payment for services is due at the time of service unless prior arrangements have been made. If I do not cancel/reschedule my appointment within 24 hours, or miss my appointment, I will be charged a NO SHOW fee of $30 for office visit appointment and $70 for scheduled procedures and biopsies. If my elective prescription (ex. Viagra) is not covered and a prior authorization is required, I will be charged a $20 fee. I also agree that, should I fail to assume that financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize **Lamia L. Gabal MD Inc. DBA Prestige Medical Group** to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier an medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

_____ _____

Date Signature of Patient or Guardian

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)

(Medicare and Medicaid Patients ONLY)

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to **Lamia L. Gabal MD Inc. DBA Prestige Medical Group** for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits for related services.

_____ _____

Date Signature of Patient or Guardian

MEDIGAP AUTHORIZATION

(Medicare Patients Only)

I request that payment of authorized Medigap benefits be made on my behalf to **Lamia L. Gabal MD Inc. DBA Prestige Medical Group** for any services furnished me by that provider. I authorize any holder of medical information about me to release to _____ any information needed to determine
(Name of Medigap Insurer)
these benefits or the benefits payable for related services.

Medicare number: _____

Secondary Insurance: _____ Policy: _____

_____ _____

Date Signature of Patient or Guardian