Saluja Medical Associates
Consent Authorization Form

_____ _____

Patient Name | Patient Date of Birth

Consent for Medical Treatment
I hereby authorization the personnel of Saluja Medical Associates to render to the patient whose name appears on this form such care as they deem necessary and appropriate.

Authorization to Release Information
I hereby authorize Saluja Medical Associates to release my final diagnosis and other medical information to the third party payers identified to determine benefits payable.

Assignment of Benefits
I hereby authorize direct payment to Saluja Medical Associates of any insurance, personal injury protection or other benefits otherwise payable to the patient or me. The undersigned acknowledges the responsibility of any co-insurance, deductible, or other sum not received by the group from any third party source.

Guarantee of Payment
I acknowledge the financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay the charges in full when rendered. In the event that the account is referred for collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance. **I understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to Saluja Medical Associates.**

Patient Certification, Authorization to Release Information
(Applies to Medicare patients only)
I hereby certify that the information given by me applying for payment under Title XVIII and XIX of the Social Security Act of third party payers is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information need for this or a related Medicare Claim.

I certify that I understand the contents of this form:

_____ _____

Signature of Patient/Guardian | Signature of Witness

_____ _____

DATE | DATE