

You are responsible for your bill. Statements are sent at the end of each month and payment is expected upon receipt. A late payment will result in a charge of 1.5% per month (annual rate of 18%). We will bill your primary Insurance for you - any other insurance billing will be your responsibility. The under signed certifies that he/she has read the above and is authorized to execute and accept the above terms in the amount of the statement billed.

I request that payment of Medicare Benefits be made either to me or on my behalf to Dr. Gabriel M. Kind/Dr. David S. Chang for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those 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 coverage is indicated in Item 9 of HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

INSURANCE AUTHORIZATION:

I authorize my insurance company to make payment directly to Dr. Gabriel M. Kind/Dr. David S.Chang

SIGNED: _____

DATE: ____/____/____

AGREEMENT TO ARBITRATION: By signing this contract, you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

Patient Name (*please print*): _____

SIGNED: _____

DATE:

_____/_____/____