Dagan MD NYC
420 Madison Avenue, Fifth Floor
New York, New York 10017

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY

INSURANCE CLAIMS AND TO ENSURE PAYMENTS OF SERVICES RENDERED.

All Private Insurance

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and /or surgical benefits, including major medical benefits to which I am entitled, to the provider of services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient

I request the payment of authorized Medicare benefits be made to me or on my behalf to the provider for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES / I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

PATIENTS NAME: (PRINT) ____ DATE: ____________________

PATIENTS SIGNATURE: ____ (OR RESPONSIBLE PARTY OF MINOR)