AUTHORIZATION FORM

Insurance Authorization & Assignment

I authorize Maryland Endocrine, P.A. to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier, (or in the case of Medicare Part B benefits to the Social Security Administration and Center for Medicare Services).

I authorize payment of medical insurance benefits which are payable to me under the terms of my insurance to be paid directly to Maryland Endocrine, P.A. for services rendered. A copy of this authorization may be used in place of the original.

This authorization may be revoked by either me or my insurance carrier at any time in writing. I understand and agree that I am financially responsible for charges not paid by my insurance company.

X_____ _____

Signature of Patient, Insured or Beneficiary Date

Release of Medical Information

I allow Maryland Endocrine, P.A. to release any information relevant to my care to my family member/relative:

_____/relationship _____unless otherwise notified.

Exception: _____

Signature: _____ Date: _____

Confirmation of Appointment/Notification

I allow Callpointe, Inc. (an appointment confirmation service hired by Maryland Endocrine, P.A.) to call me at the telephone number listed below to remind me of upcoming/rescheduling/or canceling of appointments:

Telephone # to be notified: Circle One (Home) (Work) (Cell)

Telephone # _____

Signature: _____ Date: _____