SEBASTIAN
MD

QUYNH L. SEBASTIAN, M.D., INC. **JEFFREY L. SEBASTIAN, M.D., INC.**

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MEDICARE PATIENT INFORMATION

Patient Name_____Date _____

Please sign so we may have your Medicare authorization on file:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature_____Date _____

Please sign so we may have your supplemental authorization on file:

I request authorized MediGap Benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MediGap carrier any information needed to determine these benefits or the benefits payable for related services.

Signature_____Date _____

PAYMENT POLICY

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying the 20% copayment. We file with secondary/supplemental carriers; however, in the event that the secondary does not pay within 60 days, patients will be billed the balance. Your signature below indicates that you understand and accept this policy.

Signature_____Date _____

PLEASE PRESENT MEDICARE AND SECONDARY INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.