

T.J. Hufnagel, M.D.
Marc S. Werner, M.D.
Benjamin Chang, M.D.
Elias Aliprandis, M.D.
K. Buol Heslin, M.D.
Harry Briffel, O.D.
Orly Maslavi, O.D.
Brian Lewy, O.D.

Calendar Year 2007

Patient: _____

- I hereby assign, transfer and set over to the above named physician group and facility sufficient monies and or benefits to which I may be entitled from government agencies, insurance carriers and/or others who are financially liable for the cost of care and treatment rendered to the patient.
- I authorize the above named physician group and facility to release any and all records, medical history, services rendered, or treatment given to the patient for purpose of review, investigation or evaluation of any claim submitted to my insurer(s).
- I agree that I am financially responsible for any balance that my insurance does not cover for services or treatment rendered to the patient. I agree that if the patient is not covered by medical insurance, then I am responsible for all charges for services or treatment rendered to the patient.

Date


Signature of Patient/Guarantor

Printed Name of Signee

8116106
Medicare
ok net ded

MEDICARE		HEALTH INSURANCE	
HEALTH CARE FINANCING ADMINISTRATION			
NAME OF BENEFICIARY			
ELIZABETH A BARTOLOMEO			
MEDICARE CLAIM NUMBER		SEX	
073-28-9487-B		FEMALE	
IS ENTITLED TO		EFFECTIVE DATE	
HOSPITAL (PART A)		10-01-2001	
MEDICAL (PART B)		10-01-2001	
SIGN HERE		<i>Elizabeth Bartolomeo</i>	