HeMacinto
Sound Sleep Center
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Authorization for Services Provided, Payment Agreement, and Release of Information

Patient Name: _____ Social Security Number: _____

Age: _____Date of Birth: _____Sex: M / F Telephone: _____

Address: _____ City: _____State: _____Zip: _____

Referring Physician: _____Primary Care Physician: _____

Emergency Contact:_____Phone: _____Relation: _____

Type of Insurance: □ HMO □ PPO □ Medicare □ TriCare □Other:_____

Name of Insurance Carrier: _____

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I hereby authorize Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. to submit a claim to my insurance carrier or it's intermediaries for all covered services rendered by the physician rendering the covered services for the next twelve (12) months period. Our office will file your claims to your insurance carrier(s) as a courtesy to you. Your insurance coverage is a contract between you and your insurance carrier, thus your entire account balance, including those charges filed to your insurance company, remains your responsibility; thus you are responsible for follow-up communication with your insurance company, should there be a problem in processing a claim. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of fees and charges not directly reimbursed to Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D., by any insurance policy, self-insurance program, or other benefit plan. I also authorize Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. to furnish complete information to my insurance carrier. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for deductible, coinsurance, and non-covered services. I request that payment of authorized Medicare benefits be made either to my or in behalf of Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any other information needed to determine these benefits or the benefits payable to the related service. To the best of my knowledge all of the above information is true and correct. I acknowledge I have read the notice of privacy practices.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____