Steven Lee Feldman, M.D.,P.A.
7351West Oakland Park Boulevard
Suite 104
Lauderhill, Florida 33319
phone (954) 741-5800 fax (954)741-7828

LIFETIME AUTHORIZATION

I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR ANY RELATED MEDICARE CLAIM. I REQUEST THAT THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT.
I REQUEST THAT THIS AUTHORIZATION ALSO APPLY TO ALL OTHER INSURANCES.

SIGNED_____DATE_____

PATIENT'S NAME_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Steven Feldman for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE • MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT _____ DATE _____

PARENT/GUARDIAN _____ SIGNATURE _____