CONSENT FOR TREATMENT OR PROCEDURES:

I authorize Sandip Mathur, MD to examine, treat and/or perform procedures as deemed necessary. I authorize his office and employees to carry out orders for treatment or procedures as ordered by Dr. Mathur.

FINANCIAL RESPONSIBILITY:

All professional services rendered are charged to the patient and are due at the time of service; unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Sandip Mathur, MD for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZTION TO RELEASE INFORMATION:

I hereby authorize Dr. Sandip Mathur to: (1) release any information to insurance carriers regarding my illness and treatments; (2) to process insurance claims generated in the course of examination or treatment; and (3) to allow a photocopy of my signature to be used to process insurance claims for a period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Mathur on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient Signature Date

_____

Witness