Dr. Ali Tehrani
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Authorization For Release Of Information

I certify that the information I have reported with regards to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier (or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). Either my insurance carrier or I may revoke this authorization at any time in writing.*
Patient Initials _____

Assignment Of Benefits

I hereby authorize payment of all medical benefits which are payable to me under the terms of my insurance policy to be paid directly to above named physician for services rendered.*
Patient Initials _____

Notice Of Privacy Acknowledgement

Cosmetic Surgery Waiver: (sign only if you are having cosmetic surgery)

I understand that I am to undergo cosmetic surgery and will not apply for insurance reimbursement.

_____ _____
Patient Signature Date

I hereby assume financial responsibility for and agree to make payment in full to “Alireza Tehrani, D.O., Tehrani Plastic Surgery” for all changes for services or medical supplies (Durable Medical Equipment) furnished to me or my dependents, whether this be my deductible, co-insurance, co-pay or otherwise allowable amount determined by my insurance company. This also includes services not authorized or paid for by my insurance carrier. Any balance due is to be paid in full within 30 days, unless other arrangements have been made with the business office. I understand that all co-payments, co-insurance, and deductible amounts, as determined by insurance carrier, are to be paid at the time of service. If my insurance requires a referral I understand that it is my responsibility to present the referral at the time I receive service. If I receive services without a valid referral, I understand that I am financially responsible for such services.

In the unfortunate event my account balance becomes delinquent and is referred to a collection agency or attorney, I shall be responsible for the costs of collections, also to include court costs. I certify that the financial information is given is true, accurate and complete to the best of my knowledge, and further authorize Alireza Tehrani, D.O., Tehrani Plastic Surgery to investigate any and all financial information given concerning this or any related claim. A fee of $25 will be charged for any check not honored by your bank.

I understand that it is my responsibility to inform the office of any changes to my address, phone number and insurance.

_____ _____
Patient, Insured or Beneficiary Signature Date