Uzma H. Rehman, D.O.
Hand & Microvascular Surgery

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Authorization and agreement of Medical Treatment
Insurance Benefits and Financial Responsibility

The undersigned hereby makes the following acknowledgements and agreements regarding medical treatment, insurance benefits, financial responsibility and release of information to be provided by Uzma H. Rehman, D.O. or associates or assistants to the patient whose name appears below.

Consent for examination: I understand that medical treatment may be necessary for the patient by Uzma H. Rehman D.O. or associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the rapid, partial or complete medical examination of the parts of my body I show to the examiner. I understand that the examination results will be provided to me the recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated lies with me and not the physician. I hereby release my examiner from all responsibility in connection with this examination.

Insurance benefits: As a courtesy to patients of Dr. Rehman, acceptable insurance claims will be processed. I hereby authorize my insurance benefits to be paid directly to Uzma H. Rehman D.O. I am financially responsible for all office visit charges, which are payable at the time of service, all deductibles, coinsurance (co-pay), and non covered and/or disallowed services by Medicare, Blue Cross Blue Shield, Medicaid, Private Insurance or Worker's Compensation. I am responsible for knowing my insurance plan, coverage and active status. If a balance occurs, I am responsible for payment of entire amount within three months. If it becomes necessary to refer this account to a collection agency, I agree to pay collection costs, court costs and reasonable attorney fees.

No insurance benefits: For patients with no insurance, I acknowledge I am financially responsible for all charges for services and payment is expected at time of service unless arrangement are made in advance for a payment plan. Patients are encouraged to discuss fees with finance department of the practice prior to any major medical or surgical procedure.

Release of information: I hereby authorize Uzma H. Rehman D.O. to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment.

I have read the above acknowledgement and agreements and fully understand the same.

Patient's name (Print)

Signature of Patient or Guardian Date

Relationship to patient

Witness Date

My staff and I make every possible effort to provide you with comprehensive care. If you have any comments or dissatisfaction with your care, please bring it to my attention, either in person or by letter, and every effort will be made to correct the situation.