

PATIENT AUTHORIZATION

As a courtesy to our patients, we are happy to file insurance claims on their behalf. However, the **ULTIMATE RESPONSIBILITY FOR ANY BILL IS WITH THE PATIENT**, and the patient will be held liable for the amount of the bill. If the insurance company has not made payment within 90 days of filing, you will be requested to pay the balance. Please remember that you are responsible for the bill and that your insurance policy is between you and your insurance company. Any difficulty involving the amount paid or allowed by your insurance carrier is between you and your carrier.

* The patient is responsible for obtaining referrals and/or authorizations for our office visits.

I (We) hereby give authorization for payment of the insurance and/or other benefits to be made directly to Dr. Steven Holzman and any assisting physicians, associates, technical assistants and any other healthcare providers as Dr. Steven Holzman deems necessary for services rendered. I (We) fully understand that I (We) am/are financially responsible for all charges whether or not they are covered by insurance. Furthermore, should a complication arise necessitating hospitalization or other medical care. I (We) understand that there may be additional charges for the surgeon, the hospital, anesthesia, and any lab work that may be needed. I (We) hereby authorize Dr. Steven Holzman to release all information necessary to secure payment of benefits. I (We) further agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE OF PATIENT/PARENT/OTHER LEGALLY RESPONSIBLE PERSON

DATE: _____

I (We) hereby authorize Dr. Steven Holzman to photograph specific areas of my body pertinent to the medical care that he is providing for me. Further, I understand that these photographs shall be property of Dr. Steven Holzman. These photographs may also be presented to my insurance company, if requested. **These photographs are for physician's use and insurance use only. They will not be shown to the public.**

SIGNATURE OF PATIENT/PARENT/OTHER LEGALLY RESPONSIBLE PERSON

DATE: _____

Dr. Steven Holzman and his staff are in compliance with the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), which protects the rights and maintains the privacy of every patient seen in a medical facility. I hereby agree that I have the opportunity to view the Health Insurance Portability and Accountability Act of 1996 which follows this paperwork.

SIGNATURE OF PATIENT/PARENT/OTHER LEGALLY RESPONSIBLE PERSON

DATE: _____