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 required to pay the balance. Please remember that you are responsible for the bill and that your insurance policy is between you and your insurance provider. 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 requiring hospitalization or other medical care, I(We) understand that there may be additional charges for the surgeon, 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 the physician's use and insurance use only and will not be shown to the public unless I(We) give specific written consent.**

_____

SIGNATURE OF PATIENT/PARENT/OTHER LEGALLY RESPONSIBLE PERSON

DATE:_____