



**PLEASE READ CAREFULLY. AUTHORIZATION OF TREATMENT & ASSIGNMENT OF BENEFITS:**

I authorize KIUMARCE KASHI, MD PC AND ITS ASSOCIATES to treat me and to release medical information to the insurance carriers indicated and/or other Third Parties concerning my illness and treatment. I authorize payment to KIUMARCE KASHI, MD PC for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am ultimately responsible for any amount not covered by my insurance at the time of service. I understand that I am responsible to know what my insurance benefits consist of ( co-pays, deductibles and percentage of coverage for specific procedures). I also understand that I am responsible for collection cost (40% added to the total balance), and any legal fees should it be necessary for my account(s) to be turned over to a collection agency or attorney. If I do not supply my current correct information and claims are denied for this reason I will be

(PAGE 1)

responsible for the payment and I must resolve this with my insurance carrier directly. I have received K. Kashi MD PC notice of privacy practices and office policy. I understand and agree to pay the following fees if they should arise: \$40 no show appt. fee, \$40 bounce check fee, \$155 no show stress test fee and \$200 no show sleep study fee \$10 surcharge for co-pays not paid at time of service, minimum of \$10 record request fee.

I understand that if my physician, or any person employed by or under the direction and control of my physician, is directly exposed to my body fluids in a manner which may, according to the current guidelines for the Center for Disease Control transmit the human immunodeficiency virus (HIV), Hepatitis B or C viruses that I deemed by law I law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of the test results to the person who is exposed to my body fluids.

**HIPPA AUTHORIZATION STATEMENT**

COMPLETE AND SIGN THE SECTION BELOW REGARDING CONFIDENTIAL RELEASE OF INFORMATION.

Please complete the following so that we may contact you properly and securely.

Please list the family members or any other persons, if any who we may inform about your general medical condition& Diagnoses (Including treatment, payment & health care operations).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address of where you would like your billing statements or correspondence to be sent if other than your home  
\_\_\_\_\_.

Our policy is to provide our patients with a courtesy appointment reminder phone call or lab/test results message to their home and/or voice mail. If you do not wish to receive such messages kindly provide us with a signed written statement indicating this.

By signing this form I give my written expresses consent and authorization for Dr. Kashi to view my prescription history from all other external sources.

**Please Circle one:** I have a advance directives/living will Yes  
I do not have a advanced directives/ living will NO

In signing the below, I acknowledge that I have read and understand both pages of this registration and authorization form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date  
(PAGE 2)

