Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductible and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgement.

Release of Information /Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Signature of Patient _____ Date:_____

Signature of Patient Representative _____

Relationship to Patient or Authority to sign _____

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Khan Eyelid & Facial Plastic Surgery for any services furnished to me by that physician / supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine those benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are abased upon the charge determination of the Medicare carrier.

This agreement is in effect until revoked in writing by the patient or their representative.

Name:_____

Signature Date _____

Medigap/Secondary Authorization

The following is to be filled out if you have a Medigap/Secondary insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer or employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.
I hereby authorize payment of my Medigap/Secondary benefits of Khan Eyelid & Facial Plastic Surgery, for all claims on my behalf.

This agreement is in effect until revoked in writing by the patient or their representative.

Beneficiary Signature _____ Date: _____

Medigap/ Secondary Insurer: _____

Receipt of (Notice of Privacy Practices written acknowledgment form.)

❑ I _____ , have received a copy of Khan Eyelid & Facial Plastic Surgery Notice of Privacy Practices.

❑ I _____ , refuse to accept a copy of Khan Eyelid & Facial Plastic Surgery Notice of Privacy Practices.

Two facilities that Dr. Khan participates with are the Surgery Center of Leawood and Blue Ridge Surgery Center. He has financial interest in both facilities: minority ownership in the Surgery Center of Leawood and a laser agreement with the Blue Ridge Surgery Center.

❑ Allow my health information to be shared with 3rd parties for the purpose of electronic prescribing.

New patient photo I.D. verified by _____