

PLEASE READ THE FOLLOWING AND SIGN WHERE INDICATED: RELEASE AND ASSIGNMENT

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by my physician/provider on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, the undersigned, have coverage with the insurance company as listed on the other side of this Patient Information Sheet and assign directly to Dr. Scott R. Lurie and/or Dr. Thomas Goldman all claim benefits, if any, otherwise payable to me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician whether or not paid by the insurance.

If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange prompt payment in full to clear my bill. I understand that payment is due upon receipt of my monthly statement.

This Release and Assignment is effective for the period of 2005 - 2010

Signature of Patient or Legal Guardian

****THE ABOVE AUTHORIZATION DOES NOT APPLY TO MEDICARE PATIENTS WHO ARE FEE PAYING, AND WHO, AS A COURTESY, WE ARE FILING THEIR INSURANCE CLAIMS. IF YOU HAVE MEDICARE, PLEASE SIGN YOUR NAME BELOW ACKNOWLEDGING THE INFORMATION LISTED ON THE OTHER SIDE OF THIS SHEET IS ACCURATE TO THE BEST OF YOUR KNOWLEDGE.****

Signature of Medicare Recipient