OSR

Ocean State Rheumatology LLC

Syeda SayeedM.D.
Board Certified in Rheumatology

Patient Name:_____ Provider:_____

Authorization to Release Information

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize release of medical information pertaining to medical treatment as requested by my health insurance carrier of the Health Care Financing Administration and its agencies for determination of benefits coverage.

Signature:_____
Date:_____

Authorization to Pay Insurance Benefits

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize payment directly to the above named physician or his/her billing organization, otherwise payable to me but not to exceed the regular charges for the services provided.

Signature:_____ Date:_____

Medicare

I request that payment of Medicare benefits be made on my behalf to the phyisician named above for services rendered to me. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Name of Beneficiary:_____

Health Insurance Claim Number:_____

Signature:_____ Date:_____

Address: 1030 President Avenue, Suite 305A, Fall River, MA, 02720
Phone: 508.235.6744, Fax:1.888.815.1696
Email: contact@osrheum.com

Address: 333 School Street, Suite 306,Pawtucket, RI, 02860
Phone: 401.205.1100 Fax:1.888.815.1696
Email: contact@osrheum.com

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For the Patient:

1. If you have a deductible on your account that has not been met, it is not a guarantee of payment by your insurance company. You will be held responsible for the balance if your insurance company does not make a full payment.

2. For any reason your insurance company will not reimburse the provider, you will be held responsible for all payments.

Patient's Name:_____

Patient's Signature:_____

Date:_____

NO SHOW POLICY : You will be charged a Missed Appointment fee ($100 for NEW PATIENT VISIT and $50 for FOLLOW UP) for any missed appointments or late cancellations (less than 24 hours notice). 3 or more no shows may result in dismissal from practice. Please sign below to agree.

Patient's Signature:_____

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