Patient: _____ ***DOB:*** _____

Geemson Oo, M.D., PLLC

3775 Seneca Street, NY 14224

Tel: 716-712-0920 Fax: 716-712-0922

STATEMENTS OF AUTHORIZATION

STATEMENT TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS

I authorize the release of my medical information necessary to process any submitted claim by the office of Medical Staff at Geemson Oo, M.D., PLLC. I also authorize payment of medical benefits to the above named physician for services provided to me.

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for payment under title XVII of the Social Act is correct. I authorize any holder of medical information about me released to the Social Security Administration, or its carriers, and information required to process my Medicare Claims. I request that payment under the medical insurance program be made either to me or for services provided to me.

NO FAULT/WORKERS' COMPENSATION CLAIMS

I understand that if I have requested treatment from Dr. Geemson Oo under a No Fault claim and my claim is denied I am responsible for payment for any and all treatment rendered.

STATEMENT OF MEDICAL RELEASE

I authorize the release of my medical information to other physicians whom I am under the care of (PCP's, specialists, etc). I understand that there is a charge for records requested in accordance with the NY State law.

STATEMENT OF ACCOUNT

I understand that if I have issued a personal or business check to pay for my cost of services rendered and it is returned to Geemson Oo, M.D., PLLC for any reason that it is not cashable by the bank, I am responsible for the face value of this check and a service charge of an additional **$35.00**. I understand that any balances I owe that is more than 90 days past due will be given to a collection agency.

ADDITIONAL CHARGE TO BE BILLED

I understand that I am responsible for payment of the required insurance co-payment at the time of my visit. If I request to be billed the co-payment, I understand that there will be an additional **$5.00** fee added to the co-payment.

NOSHOW AND CANCELLATION CHARGE

I understand that there will be a fee of $40.00 if at least 24 hours notice for cancellation is not given.

By signing below I acknowledge that I have read and understand the above and consent to all contents and intentions.

Signature _____ *Date* _____