LIFETIME AUTHORIZATION

DRS. KUPFERMAN, TE & DVORAK
1600 – 116th Avenue NE #104 * Bellevue, WA 98004 * 425-454-5758

I hereby consent to all medical examinations, surgical treatment, prescribed medications and procedures deemed necessary through discussion between the attending physician and myself. This authorization includes and supercedes all previous authorizations for care.

ASSIGNMENT of insurance benefits: I request that payment of authorized insurance benefits be made on my behalf directly to Dr. Kupferman, Te or Dvorak or any other provider at this location for any services rendered to me by Drs. Kupferman, Te & Dvorak or other providers. I acknowledge I am financially responsible for non-covered services. I authorize any holder to release any information required for the processing of this claim.

I agree to settle my account in full and be responsible for all charges. I have read the above and understand the contents.

Signature:_____ Date:_____

TO BE VALID THE LIFETIME AUTHORIZATION MUST BE PROPERLY SIGNED

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The patient, if physically and mentally competent, must sign on his own behalf. If he cannot sign for himself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian may sign. The source of the signatory's authority should be stated, e.g., Social Security appointed Representative payee, court appointed guardian, etc.

This form is used in lieu of the patient's signature on the "Request for Payment" form HCFA 1500 and is, therefore, an extension of that form. Anyone who misrepresents or falsifies essential information in making INSURANCE claims, may, upon conviction, be subjected to fine and imprisonment under Federal Law.