Rom R. Karin, M.D. David P. Arnstein, M.D. William S. Lewis, M.D.

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to the providers of services at Los Gatos Ear, Nose & Throat Clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits to related services.

I understand my signature requests that payment be made; authorizes the release of medical information necessary to pay the claim; and authorizes the physician's personnel to contact the insurance carrier regarding payment. If other supplemental insurance coverage is indicated on the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

I also acknowledge that I understand the doctors **do not accept Medi-Cal.**

Patient Signature ______________________ Date ______________