CHAND ROHATGI, M.D., F.A.C.S.
A PROFESSIONAL CORPORATION
THE BREAST CARE CENTER & GENERAL SURGERY PRACTICE
3735 NAZARETH ROAD, EASTON, PENNSYLVANIA 18045-1963
PHONE 610-252-1999 FAX 610-252-0573

Patient Name _____

Date of Birth_____/_____/_____

Patient's Medicare Authorization

"I, _____ request that payment of authorized Medicare benefits be made either to me or on my behalf to Chand Rohatgi, M.D., P.C. for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the HGS Administrators and its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____/_____/_____ _____

Signature Date Medicare #

Notice of Privacy Policy and Practices

I have received and reviewed the privacy policy information from Chand Rohatgi, M.D., P.C.

_____ _____/_____/_____

Signature Date

Signature on File

- ✓ I authorize use of this form on all my insurance submissions
- ✓ I authorize release of information to all my insurance companies
- ✓ I understand that I am responsible for my bill
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from
- ✓ my insurance companies
- ✓ I authorize payment direct to my doctor
- ✓ I permit a copy of this authorization to be used in place of the original

_____ _____/_____/_____

Signature Date