

Shariar Cohen, M.D. Corp.

Shariar Cohen-Gadol, M.D.

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MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT:** I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of SHARIAR COHEN, MD, A Medical Corporation (herein referred to as "SHARIAR COHEN, MD") assisting my care.
2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay SHARIAR COHEN, MD for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include cash, check, Visa, MasterCard, and debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If SHARIAR COHEN, MD is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company; SHARIAR COHEN, MD is not involved. In order for SHARIAR COHEN, MD to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that SHARIAR COHEN, MD will need to verify my health insurance coverage. In the event that SHARIAR COHEN, MD is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.
3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to SHARIAR COHEN, MD for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize SHARIAR COHEN, MD to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of SHARIAR COHEN, MD's charges, including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize SHARIAR COHEN, MD to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give SHARIAR COHEN, MD any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.
4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize SHARIAR COHEN, MD to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.
5. **PERSONAL VALUABLES:** SHARIAR COHEN, MD shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. SHARIAR COHEN, MD, A Medical Corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of Patient

Date

or Signature of Patient's Representative & Relationship

Date

Office Representative Signature

Date