AMIR SAFFARIAN, MD INC.

ASSIGNMENT OF BENEFITS

To be signed by all patients

I request that payment of authorized insurance benefits including Medicare benefits, be made on my behalf to Amir Saffarian, MD Inc. for any services furnished me by this physician. 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 payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms, including electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature:___________________________________ Date: ___________