

Vinod K. Anand, M.D., F.A.C.S.
501 Marshall Street, Suite 602
Jackson, Mississippi 39202

FINANCIAL RESPONSIBILITY:

I understand that all services rendered are my financial responsibility and that payment is due at time of treatment unless prior arrangements have been made. In consideration of the practice accepting the above patient for service, and of the services rendered or to be rendered to him or her the undersigned guarantees payment of the account of such patient and agrees to pay the same if not paid by the patient at the time of service.

Responsible Party: _____ Date: _____

RELEASE OF MEDICAL INFORMATION:

This is your authority to release medical information to my insurance companies, or my attorney if disability related, or my employer and their workman's compensation carrier if a job related injury.

Responsible Party: _____ Date: _____

MEDICARE:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the medical practice of Dr. V. K. Anand for any services furnished to me. I authorize any holder of medical information about me to release to the health care finance administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the Medicare Administration to release to the medical practice of Dr. V. K. Anand any information regarding Medicare claims for services provided by the practice. This release shall be effective for a period of twelve months from the date of service.

COMMERCIAL INSURANCE:

I hereby authorize the medical practice of Dr. V. K. Anand to submit a claim to my insurance carrier or it's intermediaries for all covered services rendered by the medical practice of Dr. V. K. Anand, and direct my insurance carrier or it's intermediaries to issue payment checks directly to Dr. V. K. Anand. I understand that I am financially responsible to Dr. V. K. Anand for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Patient / Responsible Party: _____ Date: _____