Cesar Nahas, M.D. PA

AUTHORIZATION TO RELEASE INFORMATION

I have received and will review the Notice of Privacy Practices given to me on my first visit to Cesar Nahas, M.D. PA and understand additional copies are available upon request. I authorize Cesar Nahas, M.D. PA to furnish any consulting physician, physician of my request or insurance company and its representative any information or copies of all hospital, medical records, consultation, and prescription relating to specific illness or injury. A copy of this authorization shall be effective and valid.

INITIAL _____

AUTHORIZATION FOR BILLING

I authorize direct payment to Cesar Nahas, M.D. PA the insurance benefits otherwise payable to me, but not to exceed my indebtedness to said organization on the account of charges listed herein. A copy of this authorization shall be effective and valid. I understand that I am responsible for any remaining balance my insurance company does not pay. I understand my office visit co-pay is due at the time of services unless other arrangements have been made.

INITIAL _____

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to consultation, examination and care and to consider such medical, surgical or other services determined to be necessary under the general and specific instructions of the surgeon and his assistant or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the results of consultation, examination and care by Cesar Nahas, M.D. PA.

INITIAL _____

MISSED APPOINTMENTS

I understand the office of Cesar Nahas, M.D. PA reserves the right to cancel my appointment if I am more than 15 minutes late, to be rescheduled to the next available appointment date/time.

INITIAL _____

Printed Name: _____ **Date:** _____

Signature:_____ **Home/Mobile Phone:** _____