CARDIOVASCULAR CONSULTANTS
OF KANSAS, INC

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DHAVAL R. PARIKH, M.D.

One Time Authorization

PLEASE READ AND SIGN THE FOLLOWING TO HELP US WITH YOUR INSURANCE FILING

I hereby authorize Cardiovascular Consultants of Kansas to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to same all payments for medical services rendered to me. I understand that my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to the rendering physician. I also authorize Cardiovascular Consultants of Kansas to perform any treatment which is considered necessary by the physician. A photocopy of the authorization and assignment shall be considered as valid as the original.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE SIGNED

MEDICARE & COMMERCIAL MEDICARE PATIENT'S ONLY:

	YES	NO
1. Is the patient a Veteran?	_____	_____
a. Did the VA refer you here for treatment?	_____	_____
b. Does the Patient have a VA "fee basis ID Card?"	_____	_____
2. Do you have a Federal Black Lung Card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If yes was it: ❑ Work Related ❑ Auto ❑ Injured in own home ❑ Other

Date of accident:_____

Name & Address of Workers Compensation Plan_____

4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Not retiree coverage) _____ _____

Employer Information (name, phone, address) _____

NAME OF BENEFICIARY	MEDICARE NUMBER

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the rendering physician of Cardiovascular Consultants of Kansas for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE SIGNED

NAME OF BENEFICIARY	HICN - MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering physician of Cardiovascular Consultants of Kansas for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company any information needed to determine those benefits or the benefits payable for related services. This authorization applies to all services until it is revoked by me or my representative.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE SIGNED