Alexander Simotas, M.D.
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FOR PATIENTS INSURED UNDER UNITEDHEALTHCARE, OXFORD OR AETNA ONLY

Date: _____ / _____/ _____

Patient Name: _____

Date of Birth: _____ / _____/ _____

Insurance Company:_____

Policy ID Number: _____

I hereby authorize, _____ ,(Insurance Company) to pay medical benefits to Alex Simotas, MD. I understand that this is a direct Assignment of my rights and benefits for professional medical services rendered under this policy.

I authorize the office of Dr. Simotas to file medical claims with my insurance carrier for medical services rendered on my behalf and I authorize the release of any medical or other information necessary to process this claim. I understand that I am responsible for any co-payment and any deductible at the time of service. I am aslo aware that there may be in-network out-of-pocket expenses that I may be responsible for after the insurance company processes the medical claim.

I am aware that I am fully responsible for informing/updating Dr. Simotas's office of any changes concerning my insurance policy and I understand that in the event of a denial of medical claims due to inaccurate insurance information supplied by myself, that I might be ultimately responsible for paying any outstanding charges incurred.

Effective Date: These statements shall be effective from the date of the signature below until December 31st of the current year, unless you notify Dr. Simotas's office otherwise in writing at the address written above.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____
Name of Policyholder / Patient or Authorized Person (Please Print)

_____ _____
Signature of Policyholder / Patient or Authorized Person Date:

_____ _____
Witness: Date: