

I hereby authorize the payment of benefits for my medical treatment to be paid directly to FRANCES L. GLICKSMAN, M.D.

I authorize the release of any medical information required by Dr. Glicksman regarding my own medical treatment to be released on demand to Dr. Glicksman.

FINANCIAL RESPONSIBILITY

I hereby request that my insurance carrier make payment directly to Dr. Frances Glicksman for any and all services rendered by her.

I, the undersigned, understand that Dr. Glicksman will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I also understand that should my insurance company fail to render payment for services received, I am fully responsible for all charges incurred, and will pay in full for all services. I understand that I am responsible for the payment of any and all deductibles and or co-insurance amounts and that the charges incurred are not subject to any fee schedule or reductions made by my insurance carrier. I understand that I am responsible for any balance due after payment by my insurance company. Should it become necessary for Dr. Glicksman to engage in professional collection efforts, I will be responsible for any and all additional cost of collection, including but not limited to agency fees, attorney fees and court costs.

Patient Signature

Date

Witness