ADVANCED
PLASTIC SURGERY CENTER
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ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. Assignment of Benefits: I request that payment of authorized Medicare, Medicaid, insurance, or health plan benefits be made on my behalf to Talal Munasifi, MD, PC, for any services furnished to me by or in APSC. I authorize any holder of medical or other information about me to release to such payer or their agents any information needed to determine these benefits for related services. I agree that my insurance can be billed for Workers Compensation visits that are determined not payable by Workman's Compensation. I agree to pay for any charges not covered by any third-party payer. I understand that medical insurance policies are an arrangement between an insurance carrier and me. I understand that charges for some services may be more than what some insurance companies choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan with which APSC has a participation agreement to provide covered services, I am responsible for all charges applied to my account. If a minor patient presented by someone other than the responsible party, the person who brought the minor will be accountable for charges incurred (except those covered by insurances).

Any member of my immediate family	☐Yes ☐No
Spouse Only	☐Yes ☐No
Referring Physician	☐Yes ☐No
Other (please specify)	

Patient Signature _____ Date _____

Responsible Party Signature (if not patient):_____