Said M. Ali, M.D
3261 Old Washington Road, Suite 1013
Waldorf, MD 20602
Phone: 301-705-7200
Fax: 301-705-5525

Authorization to release information and payment of benefits:

I hereby authorize direct payment of surgical/medical benefits to Dr. Said M. Ali for services rendered by him in person on under direct supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Dr. Said M. Ali to release any medical or incident information that may be necessary for either medical care or in processing for financial benefits.

MEDICARE-MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payments authorized be paid on my behalf.

A photocopy of these assignments shall be valid as the original.

PLEASE NOTE THAT YOUR COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. THEREFORE, IT IS <u>YOUR</u> RESPONSIBILITY TO KNOW YOUR CARRIER'S POLICIES, BENEFITS AND REQUIREMENTS <u>PRIOR</u> TO YOUR APPOINTMENT.

Signed_____Date_____

Authorization of Notification

I give permission for messages to be left on an answering machine at the numbers provided. I understand that no medical information will be left on the machine. Only the name of the Practice, the person calling and a message will be left.

Any pictures I give to the office may be used in the wall hangings or photo albums. The picture given for identification will not be used for this reason.

Signed_____Date_____

I UNDERSTAND THAT ANY OR ALL OF THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME.

<u>A $50.00 FEE WILL BE CHARGED TO YOUR ACCOUNT FOR ANY MISSED APPOINTMENTS IF YOU DO NOT CALL TO CANCEL OR RESCHEDULE</u>