TO ALL PATIENTS
PLEASE READ COMPLETELY AND SIGN

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Buinewicz to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Buinewicz and myself.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Brian R. Buinewicz, M.D., P C

In compliance with Medicare regulations we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health insurance? Yes____ No____
Are you entitled to Medicare because of a disability or End Stage Renal Disease? Yes____ No____
Is the illness or injury the result of an automobile accident or other injury? Yes____ No____
Has treatment for the accident or illness been authorizes by the Veteran's Admin.? Yes____ No____
Are you entitled to any benefits under the Federal Black Lung Program? Yes____ No____

I certify that this information is true and complete to the best of my knowledge.
Yes___ No___

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Signature Date