RONA Z. SILKISS
M.D., FACS
OCULOFACIAL PLASTIC, RECONSTRUCTIVE AND ORBITAL SURGERY

ADMINISTRATIVE OFFICE
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Phone 510.763.0881
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Authorizations

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Dr. Rona Z. Silkiss to release to any relevant medical practitioner, hospital, clinic or any other medical or medically related facility, insurance company, or employer, any relevant information regarding my condition. An electronic or photostatic copy of this authorization shall be considered as effective and validate as the original.

Patient or guardian signature ______________________ Date ______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to be made directly to Dr. Rona Z. Silkiss for the medical and/or surgical benefits, otherwise payable to me, for services rendered to me by this office. If my insurance company should deny payment for any service received, I will be responsible for payment for such service.

Patient or guardian signature ______________________ Date ______________

MANAGED CARE AGREEMENT

As a member of a managed care plan, I understand that, in most cases, I am responsible for obtaining authorization from my primary care physician. I also understand that if I do not obtain the proper autorization I will be responsible for the cost of my visit. In signing this agreement, I acknowledge my financial obligation and agree to work with Dr. Silkiss's office to obtain insurance authorization for each visit.

Patient or guardian signature ______________________ Date ______________