Melissa Meldrum Aabery, M.D.

Adam S. Hassan, M.D.

Eye Plastic & Facial Cosmetic Surgery

Member of the American Society of Ophthalmic Plastic & Reconstructive Surgery

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Grand Rapids, MI 49525
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LIFETIME SIGNATURE ON FILE FORM FOR MEDICARE CLAIMS

Name of Beneficiary: _____

Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Eye Plastic & Facial Cosmetic Surgery, P.C. *(AKA Plastic & Reconstructive Eye Surgery, P.C.)* for any services furnished to me by a physician of Eye Plastic & Facial Cosmetic Surgery, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I also authorize Eye Plastic & Facial Cosmetic Surgery, P.C. to release any and all medical information contained within my medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, plain clinics, or a specifically named location in the course of treatment under Melissa Meldrum, M.D., Adam S. Hassan, M.D. and Eye Plastic & Facial Cosmetic Surgery, P.C. This information may include my physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS, ARC and/or psychological information.

This authorization is in effect until I revoke it.*

Patient Signature: _____ Date: _____

**If you are in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.*

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I hereby authorize my insurance benefits to be paid directly to Eye Plastic & Facial Cosmetic Surgery, P.C. *(AKA Plastic & Reconstructive Eye Surgery, P.C.)* realizing that I am responsible to pay non-covered services (all co-pays, co-insurances and deductibles). I hereby authorize the release of medical information to the insurance carrier and their representatives.

I also authorize Eye Plastic & Facial Cosmetic Surgery, P.C. to release any and all medical information contained within my medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, plain clinics, or a specifically named location in the course of treatment under Melissa Meldrum, M.D., Adam S. Hassan, M.D. and Eye Plastic & Facial Cosmetic Surgery, P.C. This information may include my physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS, ARC and/or psychological information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____