Kakaria Ophthalmology
2005 Technology Parkway, Suite 230
Mechanicsburg, PA 17050
Phone: (717) 695-9355
Fax: (717) 695-9356
www.drkakaria.com

PATIENT'S NAME: _____
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PATIENT'S CELL PHONE: (_____)_____HOME PHONE: (_____)_____

PATIENT'S E-MAIL ADDRESS: _____

PARENT /GUARDIAN'S NAME IF APPLICABLE: _____

NAME OF PRIMARY INSURED ON CARD: _____

DATE OF BIRTH OF PRIMARY INSURED: _____/_____/_____

Lifetime Beneficiary Claim Authorization and Information Release

I request that payment of authorized insurance benefits be made either to me or on my behalf to Sandeep K. Kakaria, M.D. for any services furnished me by that physician/supplier. 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 to related services.

I understand my signature requests that a payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer agency shown. In Medicare or participating insurance carrier assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or participating insurance carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare or participating insurance carrier.

By signing this form, I also declare that all insurance information is true and correct to my knowledge and that if any of the information is incorrect that I will be responsible for payment of services.

_____ _____
Signature of Patient, POA, or Guardian Date

Acknowledgement Of Opportunity To Review The Physician Practice Privacy Policy For Kakaria Ophthalmology

This is to certify that I have been given the opportunity to review a written copy of Sandeep K. Kakaria, M.D.'s "Physician Practice Private Policy."

_____ _____
Signature of Patient, POA, or Guardian Date