CONNECTICUT ADVANCED SPINE, LLC

Ashish Upadhyay, MD

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Connecticut Advanced Spine, LLC to release medical information concerning the procedure(s) performed to the extent necessary to determine liability for payment and to obtain reimbursement. Connecticut Advanced Spine, LLC may disclose portions of the medical record to any person, corporation, or other entity who or which is or may be liable for any of Ashish Upadhyay's charges. This includes, but is not limited to, insurance companies, health care service plans, and worker's compensation carriers.

MEDICARE LIFETIME AUTHORIZATION I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Connecticut Advanced Spine, LLC of any medical and/or procedural insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed, at a rate not to exceed the regular charges. This assignment of benefits is valid for all insurance companies and programs including Medicare, private and group insurance, workers' compensation or other health plan payments.

FINANCIAL RESPONSIBILITY AND RELEASE FORM

We require payment of your copay or deductible amount, if applicable, on the date of service. If you are unable to pay this amount in full on the day of service, you will be asked to work with our billing department for the payment amount and due date of the remaining balance.

Fees for physician services, procedural assistants, Anesthesiologist/Anesthetists, pathologists, laboratory work performed outside the Center and implants are separate from Howard Lantner's fee and your responsibility for payment for these fees is between you and the provider of the service.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and/or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. You will be notified when final action (payment, denial, etc.) by your insurance carrier has been received. If any additional funds are owed, payment will be expected within 10 days of receipt of that notice.

In the event that any such amount is unpaid, you will be responsible for interest at 1.5% (18 % APR). If your account is placed with our collection agency there will be a 15% collection fee, reasonable attorneys' fees, and court costs. A $35.00 service charge will be added to your account for checks returned due to insufficient funds.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS EXCEPT AS CROSSED OFF AND INITIALED. A photocopy of this authorization shall be considered as valid as the original.

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Please Print Name

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Patient's or Guardian's Signature Date