

## Signature on File Form & Authorization of Assignment of Benefits

I, \_\_\_\_\_ (print your name) provide this signature as authorization for payment of all my medical services to High Ridge Family Practice, LLC (for any of the Family Practice associated physicians: Alan T. Falkoff, M.D. and/or Joshua B. Herbert, M.D. and/or David M. Berkun, M.D. and/or and/or Aparna Balichetty, M.D. and/or Cindy Perez, M.D.) at the following address:

High Ridge Family Practice, LLC  
30 Buxton Farms Road  
Suite 210  
Stamford, CT 06905

I understand that any services not covered by my insurance will become solely my (the patient's) responsibility.

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Date

I, \_\_\_\_\_ (print your name) authorize the release of medical or other information necessary to process this claim. I also request payment of government benefits directly to High Ridge Family Practice, LLC (as noted above for any/or all of the physicians), at the above address for all medical services rendered.

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Date

This form is valid until indicated by the above signee in writing  
of other arrangements

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## Additional Clarification on Non-covered Services and patient responsibility

Increasingly Insurance Companies are denying payments for routine services  
that are necessary for appropriate, comprehensive patient care

While the policy of this office has always been to bill the patient and hold the  
patient responsible for payment for these services, this has not always been done  
or done consistently

As of January 1, 2012 all services and testing provided by High Ridge Family Practice  
and it's Physicians if not paid by the patient's Insurance will be solely the  
patient's responsibility

This has become a particular problem with Oxford Health Plans with regards to  
simple and important items such as:  
Urine Tests – Urinalysis, Urinalysis looking for Protein in the Urine (microalbumin)  
Fingerstick Glucose Testing, Vaccines  
Vision, Hearing, Tympanometry  
Nerve Conduction Studies  
and various other tests, procedures and services

We will be more than happy to advise you of the costs of these tests should you ask  
about them, but we can not know ahead of time with each and every insurance  
company and each plan, what in office services, tests, procedures will and won't  
be covered

You may request that these tests, services and procedures not be done but these  
requests must be made before they are provided (it is the patient's responsibility to  
know their coverage and their insurance plans and what is covered and what is not),  
though a refusal to have these tests, services and / or procedures are not medically  
recommended and can hinder, compromise or delay treatments and treatment plans  
and the refusal of these tests, services and / or procedures will be noted in the  
medical records

I understand that any services not covered by my insurance will  
become solely my (the patient's) responsibility.

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Date