Patient Name _____ Insurance ID _____

A). Medicare

I request that payment of Medicare benefits be made on my behalf to Mark A. Latina, M.D. I authorize any holder of medical information about me to release to the Health Care Finance Administration (HCFA) and its agents any information needed to determine benefits payable to related services.

B). Secondary/Medigap Insurance Companies

If a Medigap or Secondary Insurance policy indicated in Item 9 of the HCFA 1500 form is necessary this authorizes release of information. I authorize payment of secondary insurance benefits be made directly Mark A. Latina, M.D.

C). Other Insurances

Harvard Pilgrim, Secure Horizons, First Senority, Tufts, BCBS, USHC, Cigna, Atena United Health , HCVM, etc. _____

I authorize payment of medical and surgical benefits to Mark A Latina, M.D. I understand that I am financially responsible for any charges whether or not paid by noted insurance company. If my insurance company designates co-payments and/or deductibles are the responsibility of the patient: I agree to pay these to Mark A. Latina, M.D. I authorize Mark A. Latina, M.D., to release any information required to process any and all claims for reimbursement on behalf. A copy of this authorization may be used in place of the original.

_____ _____

Patient Signature/Guardian Date

_____ _____

Print Patient Name/Guardian Office Representative