CONSENT FOR TREATMENT: I voluntarily consent to treatment by the medical staff of Dr. John A. Stewart, M.D., P.C. as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments, or tests. I understand that diagnostic studies, biopsies and treatment procedures such as surgery may be required, I consent to these treatments.

Patient or Responsible Party Signature _____ Date____/____/____

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to John A Stewart, MD, PC.

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY: ***Medicare Patients:*** We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying any percentage of co-payment required. We do not file with all secondary / supplemental carriers. However, **in the event that the secondary does not pay within 60 days, patients will be balance billed.**

HMO, PPO, or other Managed Care Patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services. **In the event that the patient or the physician is not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.**

Commercial Patients: If you are covered by a private, commercial plan in which our physicians are not providers you will be required to pay 50% of the total bill at the time of service. **The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.**

Patient or Responsible Party Signature _____ Date ____/____/____

MEDICARE PATIENTS ONLY: This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either the party who accepts assignment or myself. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ Date ____/____/____

If you have a supplemental policy and it automatically "crosses over" from your Medicare, we are required to keep a separate signature on file: (This is called a MEDIGAP policy.)

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Supplemental Card _____ Date ____/____/____