THE NEW YORK
AESTHETIC CONSULTANTS
PLASTIC, LASER & DERMASURGERY

DERMASURGERY
RON M. SHELTON, M.D., F.A.A.D.

NEW YORK OFFICE-BASED SURGERY, PLLC

PLASTIC SURGERY
TED CHAGLASSIAN, M.D., F.A.C.S.
WILFRED BROWN, M.D., F.A.C.S.

MEDICARE AUTHORIZATION TO RELEASE PATIENT INFORMATION

The New York Aesthetic Consultants, LLP (the NYAC) is required to keep your signature on file, authorizing it 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 carefully 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 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 to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the NYAC for services furnished to me by the provider. 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 for related services.

Patient Name: _____

Patient/Legal Guardian Signature: _____Date: ____/_____/_____

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