A. Raja Hornstein, PsyD

1330 LINCOLN AVENUE
SUITE 310
SAN RAFAEL, CA 94901-2143

Medicare Patient Information For _____

1. Notification Of Primary Care Physician

If you are under the care of a primary care physician, it may be beneficial for me to consult with that physician in regard to your treatment or to discuss any medical problems for which you are receiving medical advice. I will notify your physician concerning services that are provided by me only with your consent.

❑ A. Raja Hornstein, PsyD, is authorized to contact my primary care physician whose name and address is shown below, to discuss the treatment that I am receiving while under Dr. Hornstein's care, and to obtain information concerning my medical diagnosis and treatment.

❑ I do not authorize A. Raja Hornstein, PsyD, to contact my primary care physician with regard to the treatment that I receive while under Dr. Hornstein's care, or to obtain information concerning my medical diagnosis and treatment. I am providing you with the name and address of my primary care physician only for your records.

PLEASE COMPLETE ALL INFORMATION BELOW:

Name of Primary Care Physician: _____

Address of Physician: _____

_____

_____

Telephone number of Primary Care Physician: _____

FAX number of Primary Care Physician: _____

2. Authorization To Process Claim:

Medicare Insurance ID: _____

Secondary Insurance ID: _____

Secondary Insurer: _____

I request that payment of authorized benefits from Medicare be made to me or on my behalf to A. Raja Hornstein, PsyD for any services furnished me. I authorize the holders of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. If secondary health insurance coverage is indicated above, my signature authorizes release of the information to the insurer or agency shown. Medicare assignment is required for covered psychological services, and the psychologist agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

3. Re-Disclosure Of Information

I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and many no longer be protected. I also

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CLINICAL PSYCHOLOGIST PSY21271

calligraphy
xin: heart/mind

understand that I am not required to authorize the release psychotherapy notes. However a third party payor may request to review my medical record to verify payment for services rendered.

4. Right To Take Back Authorization

I have the right to take back my authorization; if I wish to do so, I must notify Dr. Hornstein in writing. Any information already shared by this authorization can not be taken back.

This authorization is in effect immediately upon signing and will remain in effect until _____ . If no date is entered, this authorization is in effect for one year from the date of my signature.

5. Right To Receive A Copy Of This Form

You have the right to receive a copy of this form.

Patient's signature: _____

Date: _____

A Xerox and/or facsimile copy of this authorization shall be valid as the signed original on file.