INTEGRATIVE HEADACHE CLINIC

Mark Piker, MD
Board Certified Neurologist

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MEDICARE POLICY AND PERMISSIONS

MEDICARE POLICY

Dr. Piker is participating provider with the Medicare, and he accepts rates assigned by Medicare. The actual amount to be submitted to Medicare will be determined on the day of the visit. The Medicare recipients will be billed whichever amount remains after reimbursement by Medicare and supplemental insurance (if applicable). The Medicare recipients will be required to sign the Advance Beneficiary Notice of Noncoverage (ABN) form prior to procedures informing them of the estimated costs in case Medicare does not cover a particular procedure.

To avoid late cancellations and not showing up for the scheduled appointments, we ask ALL clients (including Medicare recipients) to provide the credit or debit card information at the time of booking your appointment.

- We do not charge your card at the time of booking.
- Please see the Cancellation And No-Show Policy for details.

Initials _____

ASSIGNMENT OF INSURANCE BENEFITS

I, _____, request that the payment of authorized medical benefits be made on my behalf to Mark Piker, MD (Integrative Headache Clinic) for any services provided by him.

Initials _____

RELEASE OF MEDICAL INFORMATION TO INSURANCE

I, _____, I authorize Mark Piker, MD to release my protected medical information to my medical insurance carrier and its agents as needed to determine benefits payable for the related services.

☐ This authorization does not expire ☐ This authorization expires on _____

Initials _____

Client Name _____ Date of Birth _____

Representative Name _____

If Representative

☐ Client is a minor or is unable to sign this agreement for other reasons

☐ I'm entering into the agreement on behalf of the client as a legally authorized representative of the client

Relationship to Client

○ Spouse ○ Parent ○ Child ○ Sibling ○ Partner ○ Significant other ○ Friend ○ Other

Your signature below indicates that you have read and agree with the terms outlined in this form.

_____ _____

Client or Representative Signature Date