Declarations and agreement (Contract)

1. I, undersigned confirm that I have active health coverage as per the details given above. I hereby assign directly to **Tasneem F. Shamim, MD LLC,** all insurance benefits, if any, otherwise payable to me for the services rendered and also authorize direct payment to Tasneem F. Shamim, MD LLC.
2. I fully understand that I am financially responsible for all the charges, including **Refraction, irrespective of whether my insurance company makes the payments for these or not.**
3. I have read the office Policies & privacy policies of Tasneem F.Shamim, MD LLC clearly displayed in the reception area and confirm that these are acceptable to and binding on me, in total. Eventually in case I desire to transfer /release of the medical records to another physician or party, I am agreeable to pay the relevant documentation & handling fees, prior to transfer of records.
4. I hereby authorize Tasneem F.Shamim to release any and all medical or incidental information that may be necessary for either medical care or in processing claims/applications for benefits. I also authorize the use of my signature for availing off of the benefits.
5. I also confirm that it is my sole responsibility to understand from my insurance company, the benefits available to me, under my contract with them, particularly the limitations/exclusions. In case/s where Tasneem F.Shamim, MD LLC does not get paid, within 45 days from the date of submission of claim to my insurance company by them, by my insurance company/ies for the services rendered by her, because of my contract and I will be responsible for making total payments for these unpaid services or because of my any action, intended or unintended, I breach the provisions of my contract and I will be responsible for making total payments for these unpaid services to Tasneem F.Shamim, MD LLC immediately, at the billed rate. If Tasneem Shamim, MD LLC makes a demand for payment for services that were not paid by my insurance company and if I fail to make the payment within 30 days from the date of demand, over and above the principle amount, I will also be liable to pay interest @ 1.5% per month, from the date/s of service. In case I fail to make payment and Tasneem F.Shamim MD LLC are required to engage the services of a collection attorney/court, I will be liable to pay all expenses/charges/court fees associated with these actions.
6. I further confirm that if there is any change in any information given above, I will immediately inform the same in writing to Tasneem F.Shamim, MD LLC and that I will be fully responsible for reimbursing Tasneem F.Shamim, MD LLC in the event of denial of payment/s due to my not informing the changes to them in writing & /or in time and for the consequences thereof.
7. Irrespective of whether I am the policyholder or financial guaranteer, I assume total responsibility for all the payments to Tasneem F.Shamim, MD LLC.

Signature:______________________________ **Date:**________________

Name:______________________, **Relationship to patient**________________