1320 El Capitan Drive #200
Danville, CA 94526
Phone: (925)275-0700
Fax: (925)275-0701

Robert A. Rovner, MD
A PROFESSIONAL CORPORATION
Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgery

Vikram Talwar, MD, INC
Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgery

Patient Name: ____

Medicare Patients Only

Lifetime Beneficiary Authorization

I request payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Rovner/Talwar for any service furnished me by that physician/supplier. 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 payable to related service.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Authorization to Obtain Medication History

By signing below, I hereby authorize Dr. Rovner/Dr. Talwar/Disc and Spine to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Date: ________________________________

Patient/Legal Representative or Parent/Legal Guardian Print Name: ____________________

Patient/Legal Representative or Parent/Legal Guardian Signature: ____________________