RONALD A. STRAUSS, M.D.
18099 Lorain Avenue, Suite 537
Cleveland, Ohio 44111

BILLING AUTHORIZATION

My insurance company may or may not require a referral for services rendered. I understand if I do not have a necessary referral from my primary care physician or authorization from my insurance company for these services, I will be held responsible for payment. In addition, I understand that I am responsible for all co-payments, deductibles, and any coinsurance should they apply. If uninsured, I accept responsibility for payment in full for any services rendered.

I also authorize payment of my health care benefits for services provided by Ronald A. Strauss, M.D. be paid directly to Ronald A. Strauss, M.D.

I agree that this billing authorization is valid regardless of when I receive service(s) from Ronald A. Strauss, M.D.

X ____
Patient Name (please print)

X ____
Patient/Guardian Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Ronald A. Strauss, M.D. to utilize and release to my insurance company any medical records or information needed to facilitate the delivery of medical services to me, the payment of such services, or as otherwise required by any law, any regulation or any requirement of payers.

X ____
Patient Name (please print)

X ____
Patient/Guardian Signature

Date: ____