FAY M. AZAD, M.D.
Adult and Adolescent Psychiatry
2535 Townsgate Rd., Suite 209
Westlake Village, CA 91360
Telephone: (818) 889-8555
Fax: (805) 496-8584

ASSIGNMENTS OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I (name of patient or guardian) _____ hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to:

Fay M. Azad, M.D.
2535 Townsgate Road, # 209
Westlake Village, CA 91361
Telephone: (818) 889-8555

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the assignee to release all medical information, on behalf on dependents, necessary to secure payment from any insurance company or myself.

Signature of Subscriber or Dependent: _____

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If an appointment is missed or cancelled with less than 24 hours notice you are responsible for the full fee for the appointment.

Signature:_____ Date of Appt: _____