

**TODD H. LANMAN, M.D., INC.**  
A PROFESSIONAL CORPORATION  
120 SOUTH SPALDING DRIVE, SUITE 400  
BEVERLY HILLS, CALIFORNIA 90212

PHONE: (310) 385-7766  
FAX: (310) 385-9007

**AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND ACKNOWLEDGEMENTS**

I hereby authorize payment by my insurance carrier(s) directly to Todd H. Lanman, M. D., A Medical Corporation, and any and all Medical Associates deemed medically necessary for all medical services rendered and all major medical benefits.

I understand and agree that I am financially responsible for all charges regarding the servicing of my health care needs deemed medically necessary regardless of any insurance claims or coverage. Should the insurance carrier fail to pay any portion for my charges, I understand and agree that I and any responsible parties will be responsible for the remaining charges and agree to pay these charges no later than sixty (60) days upon completion of all insurance billing. I do hereby waive and fully give up my right to claim that the debt is not collectible by any reason of any applicable statute of limitation or by any applicable bankruptcy filing or defense.

I agree to pay all charges in a timely manner. I understand and agree that a late charge of 1.5% or \$10.00 per month (whichever is greater) will be charged on accounts past due 60 days or more. If my account is referred to a collection agency or other local action, I agree to pay the total amount due and all reasonable attorney fees/collection fees which is 50% of the total amount due.

I certify that the personal and insurance information contained on this 'Patient Information Sheet' is accurate, complete and correct and that the insurance coverage set forth on such form is in effect as of the date on this form. Should any insurance coverage change, I agree that I will notify this office of the changes within ten (10) working days and agree that I will be responsible for all charges incurred by this change should the insurance changes affect my coverage and payments to the physician. I certify that I have furnished all information regarding any and all insurance carriers and/or related parties who may be responsible for medical costs and agree to notify this office immediately of any changes, deletions and additions regarding medical coverage.

I authorize Todd H. Lanman, M.D., A Medical Corporation, to release any medical records which are reasonably necessary to process any claim which may have a bearing on benefits payable by any carrier or benefit plan.

I understand that a twenty-four (24) hour notice of cancellation of my appointment is required or a \$50.00 charge will be owed and added to my account.

I agree that a photocopy of this signed form is as valid as the original and may be used in place of the original signed form.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_