

*Scott J. Ratner, M.D., F.A.C.C., P.C.  
407 Franklin Avenue  
Franklin Square, NY 11010*

## **Authorization Form**

**AUTHORIZATION TO PAY:** *I authorize that payment of medical benefits be made on my behalf to Scott J. Ratner, M.D., F.A.C.C., P.C. for any service(s) rendered.*

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** *I authorize any holder of medical information, regarding me, to release said information to my insurance company and it's agents.*

**MANAGED CARE RESPONSIBILITY:** *Scott J. Ratner, M.D., F.A.C.C., P.C. has informed me that I am responsible for requesting any referral needed from my Primary Care Physician (PCP). I understand that I must notify the staff Scott J. Ratner, M.D., F.A.C.C., P.C. to get me an authorization or referral for the following:*

- **Dr. Ratner wants me to see a specialist.**
- **Follow up visits with a specialist.**
- **Emergency Room visits.**
- **Hospital admissions.**
- **Any surgery/procedure requiring authorization by my insurance plan.**

*I understand that payment is due when services are rendered unless prior arrangements are made. Scott J. Ratner, M.D., F.A.C.C., P.C. will act as an agent in helping me obtain reimbursement from my insurance company.*

*I permit a copy of this authorization to be used in place of the original.*

*This authorization will remain in force until termination is requested in writing by the enrollee.*

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*Patient's Signature*

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*Parent's Signature if Patient is a Minor*

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*Today's Date*