REGENT MEDICAL
RUPAL MOHAN, MD.
www.regentmedicalcare.com

16872 N. Cave Creek Rd
Phoenix, AZ 85032
P: (602) 494-7700 F: (602) 494-3377

AUTHORIZATION TO TREAT AND BILL

I consent to be treated by Regent Medical. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Regent Medical to bill my medical insurance for care that I receive and to release my information to my insurance carrier as needed to process my bills. I authorize payment/assignment of medical benefits to Regent Medical for all services performed and billed by Regent Medical

As a courtesy, Regent Medical will bill my medical insurance for me. If I do not provide complete and accurate insurance information to Regent Medical, I understand that the payment will then become my responsibility. I understand that I am responsible for all charges for treatment that I receive at this facility. In addition, I understand that I will be responsible for all charges that were not covered by my insurance.

I understand that to protect my privacy and to prevent fraud, if I cannot provide acceptable photo identification at the time of service, Regent Medical may choose not to bill my insurance and I will need to pay for my visit before I am able to see a provider.

I authorize release of my medical information to: 1. _____ Relationship: _____

2. _____ Relationship: _____

PATIENT PRINTED NAME: _____ Date: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

PATIENT PAYMENT CONSENT

Patient name: _____

Last **First**

I hereby authorize Regent Medical DBA Rupal Mohan, MD to charge my payment card for the balance of fees not paid by my insurance company.

I understand that I will receive a secured link from Payground for adding my credit card information at time of registration. I agree to follow the link and add my credit care information before my appointment.

_____ _____

Card Holder Name Card Holder Signature

Date: _____

Revised 12/15/22