ADVANCED BENEFICIARY NOTICE

I authorize Lillie A. Mosaddegh, M.D. to provide care and treatment to me and hereby request __ to pay Lillie A. Mosaddegh, M.D. all benefits accruing to me under my Medical Plan. I hereby certify that I am eligible with the insurance plan mentioned above and that I have chosen Lillie A. Mosaddegh, M.D. as my physician.

I understand that if I am not eligible for the above mentioned insurance, or do not have insurance; I am responsible for all charges for services rendered. And that it is my own responsibility to verify with my insurance company before receiving treatment that it is a covered benefit and that Lillie A. Mosaddegh, M.D is an in-network provider. _____ (Initial)

I understand I am financially responsible to the physician for all charges rendered. ______ (Initial)

_______________________________ _________________

Signature of Date