ARUNA BAKHRU, M.D.
KANDR BUILDING
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Poughkeepsie, New York 12601
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INSURANCE AUTHORIZATION PAYMENT AND INFORMATION RELEASE

I, the undersigned, authorize Aruna Bakhru, M.D. to release information to my insurance company and to my referring/primary physician. I also authorize Aurna Bakhru, M.D. to collect money for services rendered. I, the undersigned, agree to pay Aruna Bakhru, M. D. the remaining amount of money which is not paid for by my insurance company, unless otherwise arranged with this office.

The authorization to release information will end if I give written instructions to do so, and I may do this at any time.

In consideration for services rendered or to be rendered, I hereby authorize payment directly to Dr. Aruna Bakhru.

Signature:____

Date:________________________

PAYMENT/CANCELLATION POLICY

I, the undersigned, agree that I am responsible for payment at the time of visit unless an alternative payment plan is arranged with Dr. Aruna Bakhru.

Cancellations must be made at least 24 hours prior to the appointment. I agree to pay for any session missed without 24 hour notification.

Signature:______________________________________

Date:____________________