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SIGNATURE FOR BILLING

- I authorize release of this form on all my insurance submissions.
- I authorize release of information to all my insurance carriers.
- I understand that I am responsible for checking the details of my coverage with my insurance carrier. If preauthorization is required, it is my responsibility to ensure that preauthorization has been completed.
- I understand that I am responsible for my bill.
- I authorize payment to my doctor to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used instead of an original.

Name (print)_____

Signature_____

Date:_____