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SIGNATURE ON FILE

I authorize use of this form on all of my insurance claims submissions.

I authorize release of information to all my insurance companies.

I understand that I am fully responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.

I authorize insurance payments directly to my doctor.

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

Patient Name (Please Print)_____

Insurance Carrier_____

Insured Name_____

Insurance Contract Number_____

Signature_____

Relationship to Patient_____Date_____