Signature on File

I authorize use of this form on all my insurance submissions,

I authorize release of information to all my insurance companies,

I understand that I am responsible for my bill,

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies,

I authorize payment direct to my doctor,

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

Name(please print)________________________

Signature_____________________________ Date_________________