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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:_____ Medicare#. _____

Signature:_____ Date:_____