

## **INSURANCE SIGNATURE ON FILE**

Signature Date	
	I permit a copy of this authorization to be used in place of the original.
	I authorize payment directly to my doctor.
	I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
	I understand that I am responsible for my bill.
	I authorize release of information to all my Insurance Companies.
	I authorize use of this form on all my insurance submissions.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

