



SIGNATURE ON FILE/INSURANCE AUTHORIZATION CARD

- * I AUTHORIZE USE OF THIS FORM FOR ALL MY INSURANCE SUBMISSIONS;
- * I AUTHORIZE THE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANY(S);
- * I UNDERSTAND I AM RESPONSIBLE FOR MY BILL.
- * I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY(S);
- * I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR; AND
- * I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PATIENT NAME: EPSTEIN, JEFFREY
ID NUMBER:

DATE: 06/05/2018

PATIENT SIGNATURE: _____

FOR OFFICE USE ONLY:

MRN#: 0315192

Signature on File Form 02-2007