

**LOUISE I. BUHRMANN, MD, PA**

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**SIGNATURE ON FILE / FINANCIAL AGREEMENT**

**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 to 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.**

**I am responsible for any insurance deductibles and co-payments.**

**If I am not using insurance I understand that I am responsible for payment in full at the time of my appointment.**

**I understand that I may be charged for appointments canceled with less than 24 hours notice.**

**Name (Please print)**\_\_\_\_\_

**Signature**\_\_\_\_\_ **Date** \_\_\_\_\_