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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_____