



*Personalized Care with Exceptional Results*

## **Signature On File/ Insurance Billing**

**I certify that the information given by me in applying for payment is, to the best of my knowledge, true and correct. I hereby authorize release to the \_\_\_\_\_ insurance company, or its intermediaries or carriers, any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for institutional or physician services to the physician or organization furnishing the services or authorize such organization or physician to submit a claim to the above insurance company or payment on my behalf. This also applies to ancillary services.**

\_\_\_\_\_  
*(Client's Printed Name)*

\_\_\_\_\_  
*Policy #*

\_\_\_\_\_  
*(Client or health care surrogate's Signature)*

\_\_\_\_\_  
*(Date)*