SIGNATURE ON FILE

- ☐ I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- ☐ I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- ☐ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ☒ I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.
- ☐ This "Signature on File" is valid for one year from the date indicated below.

X _____ _____ _____

Signature of Beneficiary, Guardian or Personal Representative | Medicare # (if applicable) | Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative | Relationship to Beneficiary

(Vers. M2HSS04)

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