

PLEASE READ AND SIGN

I hereby authorize the physician(s) whose name(s) appear below to furnish my insurance carrier all information which the carrier may request concerning my present illness or injury.

A photocopy of this authorization shall be as valid as the original.

I hereby authorize the physician(s) whose name(s) appear below to perform routine diagnostic and therapeutic procedures as indicated.

PATIENT/PARENT SIGNATURE: _____ DATE: _____

WITNESS/PARENT: _____

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to:

Thomas A. German, M.D.

William J. Parker, M.D.

Loyde Inlow, D.P.M.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. ***I understand and agree that I am financially responsible for all charges whether or not paid by said insurance.*** I hereby authorize said assignee to release all information necessary to secure payment.

PATIENT/PARENT SIGNATURE: _____ DATE: _____