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AUTHORIZATION FOR "SIGNATURE ON FILE"

I request that payment of authorized insurance benefits be made either to me or on my behalf to the office of Joe Persinger, Ph.D. for any services furnished me by Dr. Persinger's office.

I authorize any holder of medical information about me to release to my insurance company, PPO or HMO and its agents any information needed to determine the benefits payable for related services.

I understand that my signature at the bottom of this form requests that payment be made and authorizes release of medical information necessary to pay the claim.

If other health insurance coverage is indicated in any insurance claim forms or on any electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In HMO/PPO assigned cases, Dr. Persinger agrees to accept the charge determination of the insurance carrier as the full charge. I am responsible for any deductibles, co-payments, coinsurance or services denied for any reason.

If coverage is denied for any reason, I agree to promptly pay the balance due. A charge of 1.5% per month may be added to all unpaid accounts older than 60 days.

_____ _____
(signature of beneficiary or legally responsible adult) **(date)**

_____ _____
(printed name) **(relationship to patient)**