Patient's Insurance Authorization

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider. My signature authorizes payment for all major medical and/or surgical benefits to which I am entitled from the listed insurer to pay to the listed provider assignee. I further information necessary to secure the payments(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

_____

(Patients Name - Please Print)

_____

(Patients Signature)

_____

(Insurance Company Name)

_____

(Patients Group Policy I.D.)

_____

(Patients Insurance Policy Number)

Bruce D. Levine, D.P.M.
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