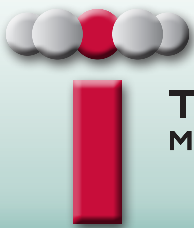

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Valencia, California 91355
TEL: (661) 753-5400
FAX: (661) 753-5401

BILLING AUTHORIZATION

Patient Name: ____

Date of Birth: __________________________

Sex: ____________

Date: __________________________

Has your billing address or insurance information changed since your last visit:

❑ Yes ❑ No

If yes, please update your address here and be sure that a current copy of your insurance card is on file.

____

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❑ I hearby authorize and direct my insurance carrier to pay directly to this provider of medical services and benefits due to me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I hereby authorize the provider to release any medical information necessary to my insurance company to process this claim. IF I AM UNINSURED, I understand that I am fully responsible for all charges.

____ Date: ________________________
Patient / Responsible Party Signature

MEDICARE RELEASE OF INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or a related Medicare claim.

____ Date: ________________________
Patient / Responsible Party Signature