Authorization to Bill

I authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim.

MEDICARE: I understand my provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

Signature required for FCN to bill insurance.

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Printed name of patient DOB

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Patient or legally authorized individual signature Date Time

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Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, etc.)