Authorization for Signature on File

If you chose to use insurance:

please read, check off the statements, and sign this form.

Please bring this with you to your first appointment.

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance carriers and to Dr. Malkin's billing service.

_____ I understand that I am responsible for my bill, including any deductible, copayment, or unpaid balance.

_____ I authorize Dr. Malkin and her billing service to act as my agent in helping me obtain payment from my insurance carriers.

_____ I authorize payment directly to Dr. Malkin from my insurance carriers.

_____ I permit a copy of this authorization to be used in place of the original.

Name: _____

Signature: _____ Date: _____