DeSantis Family Practice, PLLC

TRIPLE AUTHORIZATION FORM

ASSIGNMENT AND RELEASE

I the undersigned have insurance with _____ and assign directly to DeSantis Family Practice all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions whether manual or electronic. I further authorize DeSantis Family Practice to disclose information in my medical record, including current and previous medical records, to other physicians and healthcare providers to whom the physician may refer me for treatment.

Date: _____ Signature: _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at time of treatment and I agree that I am responsible for all fees and services rendered for treatment. I accept full financial responsibility for all charges not covered by insurance.

Date: _____ Signature: _____

MINOR/CHILD CONSENT (If applicable)

I, being the parent or guardian of _____ do hereby request and authorize DeSantis Family Practice and staff to perform necessary services for my child, including but not limited to X-rays, labs, and administration of vaccines or medications which are deemed advisable by the providers.

Date: _____ Signature: _____