Authorization to pay benefits to Physician:

I hereby authorize payment directly to above named physician of the surgical and/or medical benefits, if any otherwise payable to me for her services as described on attached claim.

Signed (Insured person)_____Date_____

****

INSURANCE: We accept most insurance plans and some H.M.O.'s. Insurance plans vary and cover anywhere from 0 to 100% of your medical and surgical costs. You are responsible for any amount not covered by your insurance at the time of service. As a courtesy, we can complete and submit your insurance forms, but you should direct any questions or complaints regarding your coverage to your insurance carrier. RESPONSIBILITY FOR PAYMENT IS YOUR OBLIGATION, REGARDLESS OF INSURANCE OR OTHER CIRCUMSTANCES!

Signed_____ Date_____

Authorization to release information:

I hereby authorize above named physician to release any information acquired in the course of my examination or treatment to my insurance company and/or other treating physicians.

Signed_____

THE UNDERSIGNED HEREBY AUTHORIZES: *SOTARA MANALO, D.O. or AMBER MORYL, PA-C or KIMBERLY TA, NP-C* - THE ATTENDING PHYSICIAN TO RENDER MEDICAL EXAMINATION AND TREATMENT - INCLUDING X-RAYS, LABORATORY AND SURGICAL PROCEDURES - IF NECESSARY FOR THE ABOVE NAMED PATIENT.

Signed_____ Date_____

****

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, **please ask for assistance.**

Payment in full at each appointment.

_____Cash

_____Personal check

****

Penalties

I realize that failure to keep this account current may result in you being unable to provide additional medical services except for medical emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signed_____ Date_____

****

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.