Anchor Bay Clinic Family Medical Center, P.C.

Patients Name: _____DOB: _____

Release of Medical Information to Insurance

I authorize Anchor Bay Clinic Family Medical Center to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, or any other insurance carrier any information needed to process any medical claim I may incur. I request payment of medical insurance benefits directly to Anchor Bay Clinic Family Medical Center, P.C. for services which I receive.

I understand that if I have no insurance coverage, or if my insurance does not cover a portion of the charges, I am responsible for payment. I also understand that payment is expected at the time of services.

_____

Insurance Company

_____

Signature Date

Notice of Privacy and Acknowledgement

I acknowledge that I have received the attached Notice of Privacy Practices.

_____

Patient or Personal Representative Signature Date

If Personal Representative's signature has been written above, please describe Personal Representative's relationship to the patient:

_____

_____