

AKLILU & COBIAN INFECTIOUS DISEASES, LLC SIGNATURE ON FILE/AUTHORIZATION



COMMERCIAL AND MANAGED CARE MEMBERS

Print Name: _____

I authorize the release of any medical information necessary to process this claim. I authorize my doctor to act as my agent in helping me obtain payment payment from my insurnace companies. I authorize you to give me reasonable and proper medical care by today's standards. I authorize payment of medical benefits directly to Aklilu and Cobian Infectious Diseases, LLC for services rendered. I understand I am financially responsible for any balance not covered by my insurance carrier. I permit a copy of this authorization to be used in place of my original signature. Should this become a collection problem, the (client/debtor/patient) assumes all costs of collection, including but not limited to, court costs, interest, and legal fees.

Patient Signature:	Date:
any services furnished to me by this group of physicians Care Financing Administration and its agents any inform services. I undersatnd my signature requests that paym claim. If "other health insurance" is indicated in item 9 electronically submitted claims, my signature authorizes cases, the physician or supplier agrees to accept the characteristics.	id, and Medigap benefits be made to Aklilu and Cobian Infectious Diseaes, LLC for a lauthorize any holder of medical information about me to release to the Health nation needed to determine these benefits or the benefits payable for related nent be made and authorizes release of medical information necessary to pay the of the HCFA-1500 form, or elsewhere on the other approved claim forms or a release of information to the insurer or agency shown. In Medicare assigned arge determination of the Medicare and Medicaid carrier as the full payement, and rance, and non-covered services. Coinsurance and the deductible are based upon dicarrier.
Print Name:	
Patient Signature:	Date:
NO SHOW FEE If a patient does not show to a scheduled appointment of this will apply to every appointment that was not cancel.	or does not call to cancel an appointment, after 3 times, there will be a \$25 fee. elled in advance after the first 3 no shows.
Print Name:	
Patient Signature:	Date:
	PRIZATION Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so, we would need your permission in order Tronic Medical Records (EMR). In doing so,
Print Name:	
Patient Signature:	Date: