INFORMED CONSENT

Insurance Verification & Billing

I hereby authorize and request Dr. Jeffrey Fritz to contact my insurance carrier (shown below) in order to determine eligibility for medical evaluation and/or covered products. I understand that my insurance company will be billed for services and/or products rendered by Dr. Jeffrey Fritz.

The following also applies to the use of my insurance to cover the cost of services and products being billed.

Authorization to Release Medical Information for Billing

- I herby authorize the release of any information regarding services by the Physician to process insurances claims and allow a photocopy of my signature to file insurance claims.

Assignment of Insurance Benefit

- I herby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the physician and the facility made directly to the physician and/or the facility. I agree this authorization will cover services rendered until this authorization is revoked. I agree that a copy of this authorization form may be used in pace of the original.

Authorization for The Release of Medical Information for Treatment

- I herby authorize the above physician and facility to obtain and release copies of my medical records and information regarding my medical history, mental or physical conditions for the purpose of further treatment and evaluation.

Insured Name **Insured DOB** **Insured Phone #**

_____

Insured Address **City, State, Zip**

Insurance Type: PPO

_____

Insurance Company / Pharmacy Plan Name

Policy #_____ **Group #**_____

Rx BIN # _____ **Rx Grp #** _____ **Rx PCN #** _____
Rx Issuer # _____

Patient Name **Insured Signature** **Date**