BUFFALO SPINE SURGERY

Center For Excellence in Spine Care Dr. Andrew Cappuccino

AUTHORIZATION FOR THE RELEASE OF HEALTH SERVICES OR TREATMENT INFORMATION

Patient Name ____ Date ________________

Physician: Dr. Andrew Cappuccino, M.D.

I hereby authorize the above named physician to release medical and other information relative to services rendered, to perform services necessary incident to such treatment, and to ensure confidentiality.

I hereby authorize payment of medical benefits to the above named doctor and I understand that I am financially responsible to the physician for charges not covered, unless other arrangements have been made. Should the account be referred for collection, the undersigned agrees to pay the outstanding bill plus interest, collection and litigation / attorney fees. The interest charged will be at a rate of 1-½ % per month back to the date of the delinquency which is 90 days after the doctors' service was provided.

I understand should my claim be rejected by an insurance company or it is determined that my claim was not a result of a Workman's Compensation injury; the undersigned shall pay the usual and customary fees for services rendered.

PLEASE PRINT NAME ____

PLEASE SIGN NAME ____

Should you wish to have balances applied to your credit card, please complete the following:

Please circle one

Discover Mastercard Visa

Card number ____

46 Davison Ct Lockport NY 14094 716-438-2973 6133 Route 219 Ellicottville NY 14731