



Dr. Joseph Sachs & Associates

INSURANCE AUTHORIZATION/SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.

- I authorize release of information to all my insurance carriers.

- I understand that I am responsible for my bill including any/all expenses not paid by my insurance

- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

- I authorize payment directly to my doctor.

- I permit a copy of this authorization to be used in place of the original.

Name: _____

Signature: _____

Date: _____