**PATIENT BILLING AUTHORIZATION FORM**

Please sign and date all provisions below.

**PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE:** I authorize the release of any medical or other information necessary to process a claim associated with the visit. I also request payment of government benefits either to myself or to the service provider, Park Oriental Medicine Center.

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURED’S OR AUTHORIZED PERSON’S SIGNATURE:** I authorize payment of medical benefits to the undersigned supplier of services, Park Oriental Medicine Center.

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE:** Should any claims my insurance be denied, or if I personally am responsible for paying the undersigned supplier, I authorize the undersigned supplier of services, Park Oriental Medicine Center, to bill me personally.

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_