

PATIENT AUTHORIZATION FORM

I, _____, hereby authorize Dr. Joanna G. Shuman, DPM, PC, to apply for benefits on my behalf for covered services rendered by Dr. Joanna Shuman; I request payment from _____ directly to Dr. Joanna G. Shuman, DPM, PC.
(name of insurance company)

I certify that the information that I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information or this related claim _____ and/or the named billing agent above. I permit a copy of
(name of insurance company)
this authorization to be used in place of the original. This authorization may be revoked either by me or the above named insurance company at any time in writing.

Signature ID Number Date

Note: The plan requires that a patient authorization be obtained only once. Preferable at the patients initial visit or encounter, and then maintained as a permanent part of the patient’s records. The plan will accept unsigned authorizations only if it is fully documented that the patient cannot sign and that there is no one who can sign for the patient.

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