

PAYMENT AUTHORIZATION

PAYMENT AGREEMENT

I understand that I am legally responsible for the payment of charges for service. Furthermore, I understand that payment for charges not covered contractually by insurance are due at the time of service.

Parent/Guardian of Insured Child

Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment by my insurance company to Lynn M. Berringer, M.D. directly. I understand that any monies received over and above my indebtedness will be refunded to me when my bill is paid in full and that I am financially responsible for charges not covered under this authorization.

Parent/Guardian of Insured Child

Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any of my child's medical records (including information relating to mental illness, use of drugs or alcohol, or HIV/AIDS) which may be requested by my insurance company for the purpose of processing an insurance claim. A copy of this authorization may be used in lieu of the original.

Parent/Guardian of Insured Child

Date