



### In Case of Emergency, Please Notify

First & Last Name, Contact 1:

Address:

City:  State:  Zip:

First & Last Name, Contact 2:

Address:

City:  State:  Zip:

### Insurance Authorization and Consent

I request that payment of authorized Medicare or other insurance company benefits be made directly to Dr. Edward Williams for services rendered by this clinic who accepts assignment.

I authorize release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow my medical records to be faxed if necessary and understand this does fall under HIPAA regulations.

I understand that clicking the "I agree" box below requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance Company.

I agree to the terms above      Date:      

|       |   |     |   |      |
|-------|---|-----|---|------|
| Month |   | Day |   | Year |
|       | / |     | / |      |

Signature: \_\_\_\_\_