Signature on File

I understand that I am responsible for my bill.
I authorize use of this form for all my insurance submissions.
I authorize release of necessary information to all my insurance companies.
I authorize Anxiety & Stress Center, P.C. and its billing service to act as my agent in helping me obtain payment from my insurance companies.
I authorize direct payment to Anxiety & Stress Center, P.C.
I permit a copy of this authorization to be used in place of the original.
I understand that if my insurance company does not pay for services rendered, I am responsible for the entire bill.

SIGNATURE_____ DATE_____

COORDINATION OF CARE

In an effort to coordinate with your physician, we routinely correspond with referring and treating physicians, including primary care physicians, gynecologists, internists, psychiatrists, and others. Please fill out the form below so that we may send summaries of treatment to your physician. Your signature at the bottom gives us permission to correspond with you treating physician while you are receiving services at the Anxiety & Stress Center, P.C. You may revoke this permission at any time.

Physician's Name_____

Adress_____

_____
city state zip

Phone ( )_____-_____ Fax ( )_____-_____

Signature_____Date_____