

Authorization Form

I, the undersigned certify that I have insurance coverage

(name)

And assign directly to Dr. Pandelis Baniyas PhD, MD all insurance benefits.

I understand that my insurance may not cover particular services, routine screens, and annual physicals, and certain blood tests.

If my insurance denies payment, I agree to be personally and fully responsible for payment of all charges.

I authorize the release to my insurance carrier any medical information necessary to process this claim, and I authorize payment of medical benefits directly to the designate provider.

Patient Signature

Date