Patient Signature Form

This could be a direct link to your e-signature page!

All fields marked with * are required and must be filled.

Patient First Name * Patient Last Name *

Applicable Dates of Service: From * To *

Requiring signature to authorize:

- I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by the service provider.
- I understand that I am financially responsible for the services and supplies provided to me, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to what is paid by my insurance.
- I agree to immediately remit any payments I receive directly from insurance or any other source for the services provided to me and assign all rights to such payments to the service provider.
- I authorize the healthcare provider or service entity to appeal payment denials or other adverse decisions on my behalf without further authorization.
- I authorize and direct any holder of medical information or other relevant documentation about me to release such information to service provider, its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, along with their respective agents or contractors, as may be necessary to determine benefits payable for services provided to me, whether now, in the past, or in the future. A copy of this form is as valid as an original.

Signature * Patient Signature (or Authorized Representative)

First Name * Last Name * Date *

Authorized Representative

Choose One

If signing on behalf of the patient, please indicate relationship

Relationship