FOURROUX PROSTHETICS *Building Relationships for Life*

Patient Insurance Authorization/Release Form

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the use of this form on all of my insurance submissions.

Fourroux Prosthetics, Inc. shall act as my agent in helping me obtain payment from my insurance companies including obtaining medical records from other physicians and/or medical providers which may be requested by my insurance companies.

I understand that my signature requests that payment be made and authorizes release of medical information to my insurance companies, necessary to process the claim, with payment to be made to ***Fourroux Prosthetics, Inc.***

_____

Print Name

_____ _____

Patient / Authorized Signature* **Date**

_____

***Relationship to Patient**