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## PATIENT AUTHORIZATION

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Patient's Name: \_\_\_\_\_

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize the release of medical information, pertaining to medical treatment as requested by my health insurance carrier or the health care financing administration and its agencies for determination of benefits coverage.

Patient or Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ■ Authorization to Pay Insurance Benefits

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize payment directly to the above named NYC Speech-Language Pathologist P. C. or his/her billing organization, otherwise payable to me, but not to exceed the regular charges for the services provided.

Patient or Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_