



## **PAYMENT AND TREATMENT AUTHORIZATION**

I, the undersigned, authorize payment of medical benefits to Internal Medicine & Pediatrics Wellness Center P.L. and authorize the release of medical information necessary to process my insurance claim(s). I understand that I am responsible for all charges regardless of insurance coverage.

\_\_\_\_\_ Initials.

I authorize my physician to provide immunizations and perform tests and procedures deemed necessary for my/ my child's care in the office \_\_\_\_\_ Initials. I also consent to the release of information to a provider I am referred to for specialized care \_\_\_\_\_ Initials.

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_