

TRIPLE AUTHORIZATION FORM

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to **Claremont Family Medicine** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions whether manual or electronic. I further authorize **Claremont Family Medicine** to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physicians my refer me for treatment.

Date: _____ Signature: _____

Witness: _____ Relationship to Patient: _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize **Claremont Family Medicine** and staff to perform necessary services for my child, including, but not limited to X-Rays, Labs and administration of anesthetics which are deemed advisable by the physician.

Date: _____ Signature: _____

Witness: _____ Relationship to Patient: _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at time of treatment and I agree that Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date: _____ Signature: _____

Witness: _____ Relationship to Patient: _____