INSURANCE AUTHORIZATION SHEET

Mohawk Valley Orthopedics, P.C.

Russell Cecil, MD, Ph.D. Gerald Ortiz, MD Joseph Popper, MD

5010 State Highway 30, Suite 205, Amsterdam N.Y. 12010 P: (518)842-2663 F: (518)842-4861

434 South Kingsboro Ave Ext, Johnstown, N.Y. 12095 P: (518)773-4242 F: (518)773-4246

Signature On File

- ✓ I authorize use of this form for all my medical submissions.
- ✓ I authorize the release of information to all my insurance companies.
- ✓ I understand I am responsible for my co-pays and bills if insurance does not pay.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
- ✓ I authorize payment directly to my doctor.
- ✓ I permit a copy of this authorization to be used in place of the original.

Name_____

Signature_____Date_____