Laura Johnson, NP, PC
FAMILY PRACTICE NURSE PRACTITIONER
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AUTHORIZATION FOR TREATMENT, BILLING OF INSURANCE & RELEASE OF INFORMATION

Patient's Name:_____ Date of Birth: _____

I hereby consent to treatment by clinic providers for myself or the person listed above. I authorize any holder of medical or other information about me to release to my insurance company or the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers any information needed for this or relates to Medicare or other claims. I permit a coy of this authorization to be used in place of the original, and request payment of Medicaid insurance benefits either to myself or the party who accepts assignment.

I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment, including health insurance and other medical plans.

Signature: _____ Date: _____

Relationship to Patient:_____