Cedar Hill Primary Care, LLC
Authorization for Release of Information and Payments

I hereby authorize Cedar Hill Primary Care, LLC to furnish my health insurance company all the information which said insurance company may request concerning treatment for me or my dependent(s). I hereby assign to Cedar Hill Primary Care, LLC the medical and/or surgical benefits to which I or my dependent(s) are entitled under my health insurance plan(s). I understand I am financially responsible for any balance not covered by my insurance.

I understand I am responsible for payment of all co-payments, deductibles and co-insurance at time of service.

In addition, I agree to pay any additional charges related to the cost of collections (included but not limited to, collection agency fees, reasonable attorney fees and court costs) in the event that I would fail to pay my bill.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE VALID AS THE ORIGINAL

Guarantor
Signature:_____
(Financially responsible adult/parent/guardian)

Date:_____