Signature on File

I authorize the RELEASE of any medical or other information to process claims.

I authorize the payment of medical benefits to Andrea Berez, MS, RDN for services provided.

I understand that I am responsible for my bill including any co-pay or co-insurance or deductible under my policy.

If I am not insured, or my insurance company will not authorize or pay for my visits, I understand that I am responsible for my bill and that your office visit for my initial visit is $180 and follow-ups are $90.

I understand that the policy of this office is to provide at least 72 hours notice in the event that I must cancel an appointment and that I will be liable for your office cancellation fee of $100 if I fail to do so.

I permit a copy of authorization to be used in the place of the original.

_____

Patient's or Authorized Person's Signature

_____

DATE