Insurance Agreement

I certify that I, and/or my dependent(s) have insurance coverage with_____(Name If Insurance Company).
I consent & assign directly to Dr. Jay Ritter all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance I authorize the use of my signature on all insurance submissions. Dr. Jay Ritter may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____
Relationship to Patient Date