PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the Medical Insurance either by electronic or manual method by the listed Provider below. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed Insurer below to pay the listed Provider Assignee. I further authorize the Assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient's Name	Patient's Signature

Provider's Name
Dhaval Patel / Adam Shapiro

Address
984 West Foothill Blvd. Suite B

City	State	ZIP
Upland	**California**	**91786**

Patient's Insurance Company:

Policy Number:	Group Policy I.D:

Date: