Grace Medical Services, LLC

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AUTHORIZATION FOR INSURANCE CLAIM SUBMISSIONS

1. I _____ give permission for Grace Medical Services, LLC. to give me medical treatment.
2. I allow **Grace Medical Services, LLC** to file for insurance benefits to pay for the care I receive.

   I understand that:

   - **Grace Medical Services, LLC** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature **Date**

_____ _____

Parent or Guardian Signature [For children under 18] **Date**

_____ _____

Print Name **Date**