

**Authorization to Release Information and Agreement to Pay**

I hereby voluntarily consent and authorize Super Shot, Inc. and VaxCare to release any information acquired in the course of treatment to process insurance claims. In consideration of services rendered and to be rendered by Super Shot, Inc., I agree to pay for all services performed. This authorization shall remain in effect indefinitely unless specially amended by the patient or legal guardian.

 **Initial:­­­­\_\_\_\_\_\_**

**Authorization to pay Insurance Benefits:**

I hereby assign to Super Shot, Inc., care of VaxCare, benefits which are due or are to become due to me as a result of medical services for the said patient. I hereby authorize the payments to be made directly to Super Shot Inc., care of VaxCare. I understand that I am financially responsible for any portion of the charges for medical services, which for any reason, are not paid by my insurance company. I hereby give permission to Super Shot, Inc., and VaxCare to contact my insurance carrier to facilitate the process of my claim. This authorization shall remain in effect indefinitely, unless specifically amended by the patient or legal guardian.

**Initial:\_\_\_\_\_**

**Insurance Status/ Payment Options (please choose one):**

\_\_\_\_\_ The patient currently has insurance and would like services to be billed through their policy.

* + I understand that it is my responsibility to provide the correct policy information
	+ I understand that it is my responsibility to pay all co pays, coinsurance, and all fees not covered by my plan.

\_\_\_\_\_ The patient currently has insurance, but does NOT want services to be billed through their policy.

* + I understand that this will apply to all services, starting today and until I sign a new agreement.
	+ I understand that I am personally responsible for the payment of services rendered and not my insurance company, nor Super Shot, Inc.
	+ I understand that I must pay for services before leaving, on the date the service is received.

\_\_\_\_\_ The patient is currently un-insure/under-insured and will pay for today’s services by cash, credit/debit, or check.

* + I understand that I must pay for services before leaving, on the date the service is received.

**Patient name (please print):­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient or Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_**