Peter Grant MD
610 S. Maple, Suite 3000
Oak Park, IL 60304

# AUTHORIZATION, ASSIGNMENTS, AND RELEASES

**Authorization of Care**
I hereby authorize the Physician Peter Grant and medical staff to examine me, to perform test, and procedures as they feel in their judgment are reasonable and necessary in the diagnosis and treatment of my case. No test or procedure will be performed without informed consent and prior approval by me. I acknowledge that no guarantees will be made to me as to the result of treatments and examinations done.

**Authorization to release information**
I hereby authorize the physician Peter Grant and medical staff to furnish to my health insurance company and/or the insurance company's review agency, or other third party payer(s) or their designated agents, all the information, all the above named entities may request concerning treatment for myself and my dependents, including medical records.

**Authorization to assign insurance benefits**
I hereby authorize the physician Peter Grant and medical staff the medical and/or surgical benefits to which my dependents or I are entitled under my health insurance plan. I guarantee payment in full for all amounts not covered by the assigned third party payer(s).

I understand that payments for services may be made by credit card, approved check, or cash. Returned checks will be issued a $30.00 return fee. Balances older than 30 days will be subject to finance charges of 1.5% per month. All collection fees will be charged to your account in the event of nonpayment. Under a managed care plan which is contracted with Peter Grant, MD, I will be responsible for payment of all co-pays, deductibles and non-covered services.

I agree to pay for all the charges not covered by the insurance.

I have read this form and understand its consents.

**Patient Name (printed)**_____

**Signature** _____ **Date**_____

**Relationship** _____