

BUFFALO SPINE SURGERY, PLLC

Andrew Cappuccino, M.D./Franco Vigna, M.D.
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Lockport, New York 14094

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AUTHORIZATION FOR THE RELEASE OF HEALTH
SERVICES OR TREATMENT INFORMATION

Patient Name _____ Date _____

Physician: Andrew Cappuccino, M.D./Franco Vigna, M.D.

I hereby authorize the above named physicians to release medical and other information relative to services rendered, to perform services necessarily incident to such treatment, and to ensure confidentiality.

I hereby authorize payment of medical benefits to the above named doctor and I understand that I am financially responsible to the physician for charges not covered, unless other arrangements have been made. Should the account be referred for collection, the undersigned agrees to pay the outstanding bill plus interest, collection and litigation/attorney fees. The interest charged will be at a rate of 1 1/2% per month back to the date of delinquency which is 90 days after the doctors' service was provided.

I understand should my claim be rejected by an insurance company or it is determined that my claim was not a result of a worker's compensation injury, the undersigned shall pay the usual and customary fees for services rendered.

Signature: _____

Should you wish to have balances applied to your credit card please complete the following:

Please circle American Express Discover Mastercard Visa

Card# _____ Exp Date _____

Signature _____ Date _____