WILLIAM R. BOND, JR., M.D., MBA, F.A.C.S.

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Washington, D.C. 20010
202.726.7770

ANNUAL AUTHORIZATION FORM

Patient Name ____ Date ____________________
(Print)

Patient's date of birth _____________________ Patient's SS# ________________________

Guardian's Name __________________________________ Phone _________________________
(Print)

AUTHORIZATION FOR TREATMENT

I consent to examination, treatment and procedures, which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to this physician for services covered by insurance. I assume financial responsibility for, and agree to make payment in full to this physician for all charges for services or medical supplies furnished, not covered or paid by my insurance carrier.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize this physician to release to my insurance carrier and its designated agents any information concerning medical care, advice, treatment or supplies provided to the patient for purposes of administration, review, investigation or evaluation of coverage claims and utilization of services. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Should there be any tests such as imaging services, lab tests, and/ or audiology exams, I understand that I am to call the office of William R Bond, Jr., M.D. to arrange a return office visit appointment to receive the test results.

Signature of Patient or Guardian ____