# Permission to Bill Insurance

I, ________________________________________, do hereby give Maine Natural Medicine and Dr. Marly Sachsman permission to bill my insurance.

Insurance Provider:

______________________________________________________________________

Insurance ID:

______________________________________________________________________

Insurance effective date:

______________________________________________________________________

Copayment:

______________________________________________________________________

I understand that it is my financial responsibility to provide payment for all my visits, services and supplements at Maine Natural Medicine. If my insurance company fails to pay for any part of my visit(s) I give Dr. Sachsman and Maine Natural Medicine permission to bill my credit card. My credit card information is:

Card Type: ______________________________ Expiration Date: ______________

Card Number: ______________________________ Security Code: ______________

Please note name and address on card if different than patient records.

I will be notified by email at the time any such charges are put through on my credit card.

Patient Print Name:

______________________________________________________________________

______________________________ ______________

Patient Signature Date

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