

Charles H. Thorne, MD, PLLC 812 Park Avenue, New York, NY 10021 (212) 794-0044

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Patient's Name: _____

Who is the Subscriber for the patient's Primary Insurance?

Name: _____

SS#/Date of Birth: _____

Relationship: _____

Who is the Subscriber for the patient's Secondary Insurance?

Name: _____

SS#/Date of Birth: _____

Relationship: _____

I authorize payment of all medical benefits to Charles H. Thorne, MD, PLLC and understand that I am responsible for all remaining balances not covered by my insurance carriers. A copy of this signed authorization can be accepted as an original.

Signature (Parent or Guardian if patient is minor)

Date

I hereby authorize Charles H. Thorne, MD, PLLC to furnish all information necessary including photographs to process my claims from this date forward to all of my insurance carrier, and to act on my behalf regarding insurance appeals. A copy of this signed authorization can be accepted as an original.

Signature (Parent or Guardian if patient is minor)

Date