CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

I authorize the physicians and extenders of Capital Allergy and Respiratory Disease Center to perform such diagnostic procedures and/or treatment, as they deem necessary. I authorize my insurance carrier, or its intermediaries, to make payment directly to Capital Allergy and Respiratory Disease Center for my medical benefits otherwise payable to me for medical services rendered. I understand that I am required to provide proof of insurance for each and every office visit and am financially responsible for all charges whether or not paid by my insurance carrier. I authorize Capital Allergy and Respiratory Disease Center to release any medical information necessary to process and secure payments for charges to my insurance carrier or its intermediaries.

_____ _____

Signature Date

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