Path of Life Healing Center
Stimulating Cellular Beauty

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NUTRITION CLIENT: AUTHORIZATION TO BILL INSURANCE

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PLEASE NOTE ALL THREE (3) AREAS MUST BE SIGNED IN ORDER FOR OUR OFFICE TO BE ABLE TO BILL YOUR INSURANCE COMPANY

HEALTH CARE PROVIDER: Venetta Kalu, LDN, CNS, ND
RESPONSIBILITY: Office Manager
OFFICE: Path of Life Healing Center, Beltsville, MD 20705
CONTACT DETAILS: vkalu@pathoflifehealing.com | 301-377-4523

AUTHORIZATION TO BILL YOUR INSURANCE COMPANY:

I, _________________________ hereby give my consent for PATH OF LIFE HEALING CENTER.

to bill my insurance company (Insurance Provider) ____

for services rendered to me by the above-mentioned health care provider.

* PATIENT SIGNATURE: ____

* SUBSCRIBER SIGNATURE: ____

ASSIGNMENT OF BENEFITS:

I authorize the above-mentioned insurance company to pay medical benefits directly to the above-mentioned health care provider.
* PATIENT SIGNATURE: ____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize, PATH OF LIFE HEALING CENTER to release necessary medical information to the above-mentioned insurance company and/or to their designated managed care company as is required by the insurance company to process the insurance claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases (STD), psychiatric disorders/ mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment to Path of Life Healing Center.

* Date: ___________ | Signature: ____________________________________ | Date of Birth: _____________