FINANCIAL RESPONSIBILITY

* Please Read and Initial *

I hereby authorize Payment to Dr.Duru D.M.P, of any Medical or Surgical Benefits.

Initial _________________

I hereby authorize Dr.Duru D.M.P , to release medical records including HIV testing and/ or drugs/ alcohol use and testing as requested by representatives of insurance companies or other related organizations for payment of claims, for quality assurance/ management or utilization management purposes. Despite the risk that information being transmitted electronically or through fax communication devices may be intercepted or inadvertently transmitted to people not authorized to receive the information.

Initilal __________________

I understand that some procedures / services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment of such services.

Initial __________________

Patient signature/ Guardian signature