Erika Eeds, D.C.
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SIGNATURE ON FILE

I authorize use of this form on **all** my insurance submissions.

I authorize release of information to all my **Insurance Companies.**

I understand that **I am responsible for my bill.**

I authorize my doctor to act as **my** agent in helping me obtain payment from my insurance companies.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

Name_____

Signature_____Date_____