

## Signature on File Form & Authorization of Assignment of Benefits

I, \_\_\_\_\_ (print your name) provide this signature as authorization for payment of all my medical services to High Ridge Family Practice, LLC (for any of the Family Practice associated physicians: Alan T. Falkoff, M.D. and/or Joshua B. Herbert, M.D. and/or David M. Berkun, M.D. and/or Saloni Anand, M.D. and/or Elena E. Gazzola, M.D.) at the following address:

High Ridge Family Practice, LLC  
30 Buxton Farms Road  
Suite 210  
Stamford, CT 06905

I understand that any services not covered by my insurance will become solely my (the patient's) responsibility.

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Date

I, \_\_\_\_\_ (print your name) authorize the release of medical or other information necessary to process this claim. I also request payment of government benefits directly to High Ridge Family Practice, LLC (as noted above for any/or all of the physicians), at the above address for all medical services rendered.

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Date

*This form is valid until indicated by the above signee in writing  
of other arrangements*