

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 Aparna Balichetty, M.D. and/or Gil M. Fernandez, 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