DR. PARRINGTON, DR.FREEMAN & DR. LAM
13901 McAuley Blvd, Ste. 220
OKLAHOMA CITY, OK 73134
(405) 755-6102 FAX (405) 755-6140

AUTHORIZATON/AGREEMENT OF PAYMENT FOR SERVICES

PLEASE CHECK EACH OF THE FOLLOWING AS APPLICABLE AND SIGN AT THE BOTTOM

_____ I authorize medical treatment for my family member(s). I do not have any insurance. I acknowledge payment is to be made on the day of service.

_____ I authorize medical treatment for my family member(s). I understand I am responsible for all charges incurred regardless of insurance status. I understand Dr.'s Parrington, Freeman and Lam will file my insurance. However, as the parent and/or authorized responsible party, I am ultimately responsible for payment. I agree to pay my coinsurance (copay) at the time of service and the balance and deductible promptly upon the receipt of a statement issued from Dr.'s Parrington, Freeman and Lam.

_____ I authorize my insurance company to pay Dr.'s Parrington, Freeman and Lam on my behalf. This agreement will remain in effect until such time as the patient-physician relationship is terminated.

_____ My signature or that of my spouse or authorized representative below authorizes release of information necessary to secure payment from my insurance company.

Signature: _____ Date: _____
(Parent)

Signature: _____ Date: _____
(Spouse)

Signature: _____ Date: _____
(Authorized Representative)