ATUL KAPADIA, MD
2280 OPITZ BLVD. STE# 210
WOODBRIDGE, VA 22191

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 to 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.

Should my account go to collection agency or Attorney, I will be responsible for my fee at 25% of my bill.

Name (please print)_____

SS#_____

Signature _____Date_____