

INSURANCE AUTHORIZATION-SIGNATURE ON FILE
JOHN L. POURNELLE, JR., D.M.D.

5580North Third Street
Soperton, Ga 30457
(912) 529-6171

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

Today's Date

Signature of Patient or Insured

Witnessed By