

Duke

SPINAL CENTERS

400 E Red Bridge Rd Suite 113 Kansas City, MO 64131

816-942-9578 Fax: 816-942-9589

SIGNATURE ON FILE FORM

By signing this form I, _____;

- Authorize the use of this form on all Insurance submissions;
- Authorize Release of Information to all Insurance Companies;
- Understand that I am responsible for my bill;
- Authorize Dr. Duke as my agent in helping me to obtain payment from my insurance companies;
- Authorize payment direct to Dr. Duke and;
- Permit a copy of this authorization to be used in place of the original.

Signature: _____

Social Security # _____

Date: _____

Printed Name (Patient or Representative): _____