Athens Clinic
15100 Plaza South Drive
Taylor, MI 48180
(734) 287-3700
Fax (734) 287-1859

I have been informed that during the course of my treatment at Athens Clinic, certain laboratory tests will be sent to an outside laboratory. If my insurance requires a particular laboratory, I am responsible for notifying Athens Clinic, I understand that I will be responsible for any deductibles, co-payments, and services not covered by my insurance company.

_____ _____

Signature **Date**

Commercial Insurance & Blue Cross
"One Time Authorization Agreement"

I, the undersigned certify that I (or my dependent) have insurance coverage with

_____ and I authorize payment of medical benefits
(Name of Insurance Company)
directly to Dr. _____. I also authorize Athens Clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature **Date**