LIFE CENTER, INC.
6997 Lincoln Highway
Thomasville, PA 17364-9208

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 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.

Name (Please Print) _____ Medicare # _____ (if applicable)

Signature _____ Date _____