M A C O U P I N

Family Practice Centers, LLP

Consent for Insurance to Make Payment

Name:______________________________ **DOB:**____________ **Date:**____________

I authorize my insurance company to make all payments to Macoupin Family Practice Centers, LLP.

I authorize the release of all medical records to the referring physician and to my insurance company with regard to processing my claim.

I understand that I am responsible for payments of all charges including those incurred with the collection of any delinquent accounts.

This agreement is effective immediately and will remain intact until the patient revokes consent.

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Signature Relationship

15574 Route 108
Carlinville, IL 62626
(217) 854-4319
Fax (217) 854-2765

715 West Broadway
Gillespie, IL 62033
(217) 839-4491
Fax (217) 839-2689

115 North Poplar
Mt. Olive, IL 62069
(217) 999-4751
Fax (217) 999-2317