David Bruce Christian, M.D.
500 Old River Road, Suite 145
Bakersfield, CA 93311-9509

(661) 664-0434 Ph
(661) 664-0432 Fax

Signatures of Authorization and Acknowledgement

Patient's Name (please print) _____ Date of Birth (mm/dd/yyyy) _____

Personal Representative or Responsible Party (please print) _____ Relationship to Patient _____
(i.e. parent, legal guardian, healthcare surrogate, or other)

I have received a copy and have had the opportunity to review both Dr. Christian's Financial Policy brochure and "Notice of Privacy Practices" brochure.

I understand that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier.

I authorize payment of the medical and/or surgical benefits, if any, to Dr. Christian.

I authorize to Dr. Christian to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance carrier.

Signature of patient or other responsible party _____ Date Signed (mm/dd/yyyy) _____