## RICARDO BERNAL, MD

8751 Commodity Circle, Suite 3
Orlando, FL 32819


Patient's Name: ____________________________________________

### AUTHORIZATION TO FILE CLAIM AND RELEASE INFORMATION TO INSURANCE TO PROCESS CLAIMS

I understand I am responsible for payment of ALL services provided Ricardo Bernal, MD.

**The cost of ANY SERVICES agreed upon at the office with Dr. Bernal / B & T Partners LLC and not covered or denied by Insurance, will be my responsibility.**

***We will attempt to submit claims to your insurance company once. If any initial claim is denied for a service provided, you will be asked to pay the claim amount out of pocket: a receipt will be provided and any appeal process WILL BE YOUR PERSONAL RESPONSIBILITY.***

I hereby authorize Ricardo Bernal, MD / B&T Partners LLC to release medical, psychiatric, HIV and substance abuse information contained in my and/or my child's record to insurance carrier for processing of claims.

I hereby request and authorize claim submittal electronic or paper and payment of authorized insurance benefits to be made either to me or on my behalf to Ricardo Bernal, MD / B&T Partners LLC for the services provided

_______________________________________ _____________________________

**Signature of Patient or Authorized Representative** **Date**

### Consent for Treatment

I hereby give consent to Ricardo Bernal MD to provide Psychiatric Evaluation and Treatment to myself and/or the patient named above.

_______________________________________ _____________________________

**Signature of Patient or Authorized Representative** **Date**

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**Relationship to Patient**
**(If signed by authorized Representative Patient)**