

## Payment, Release and Contact Authorization Form

Dr. Mark E. Laursen, M.D., M.D.(H), A.B.I.H.M., N.M.D.  
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### Client Information:

Please print the following:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Secondary phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Marital status: Married – Single – Divorced (Circle)

Sex: Male – Female \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Name of person responsible for payment if other than yourself: \_\_\_\_\_

**Authorization for Payment:**

Payment is due at time of submission of your consultation forms.  
Please call office first for secure payment.

I will use the following as preferred method of payment:

(Circle method)

Cash ▪ MasterCard/Visa ▪ Check

Credit Card Number (please print clearly) \_\_\_\_\_

Expiration date: \_\_\_\_\_

Security code: \_\_\_\_\_

Name and Billing address for card:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I acknowledge that I am the signer for this card and I authorize billing for services rendered to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Dr. Laursen does not bill insurance or Medicare, however a super bill can be provided to you upon request, for your own submission to your insurance company. Dr. Laursen cannot guarantee payment to you from any insurance company.

**General Release Waiver**

I, \_\_\_\_\_ acknowledge that I am choosing to contact Dr. Mark Laursen MD as a consulting HOMEOPATHIC, NATURAL & HOLISTIC physician; that I will maintain a private internal medicine, family practice or general practice doctor for all my basic life & limb medical needs. I acknowledge that Dr. Laursen cannot always respond to my medical situations and problems in a timely manner.

I acknowledge some risk to all medical and health undertakings in life, including accident and death, and that outcomes cannot be guaranteed. I understand that all therapies may not be standard in conventional medicine but I choose to integrate food, nutrient, herbal, homeopathic and other therapies for my better health & well-being. I acknowledge that I am aware that I can purchase any prescriptions or over-the-counter products at any location of my choosing.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Contact Authorization:**

Your Name: \_\_\_\_\_

Please list everyone that you authorize Dr. Laursen to contact or speak with regarding your medical record and health:

1. Name \_\_\_\_\_ ph # \_\_\_\_\_

2. Name \_\_\_\_\_ ph # \_\_\_\_\_

3. Name \_\_\_\_\_ ph # \_\_\_\_\_

4. Name \_\_\_\_\_ ph # \_\_\_\_\_

Please list the methods of communication you authorize Dr. Laursen to use to contact you:

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Facsimile \_\_\_\_\_

E-mail \_\_\_\_\_

Mailing address \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_