NAME_____

SS#_____

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorized release of all medical information necessary to process my insurance claims and is pertinent to my medical care. I authorize the release of medical records to and from all referring physicians. I assign all medical and/or surgical benefits including Major Medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT. Unpaid patient due balances over 30 days are subject to additional charges of 1.5%/month and collection fees if applicable.

Patient_____Date_____
(Parent if minor)

Responsible Party_____Date_____

Witness_____Date_____