

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign)

I hereby authorize the physician to release any information acquired in the course of my examination or treatment to my insurance carrier; and I hereby assign to the physician all payments for medical services rendered to myself. I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days if no response is received, I understand that I could be responsible for any charges. I understand that I am responsible for payment of any amount that is not covered by insurance.

Assignment of Insurance Benefits:

The undersigned hereby authorizes the insurance carrier listed, or any insurance carrier represented as contractually responsible for payment in whole or part of the patients healthcare bill, to pay directly to the physician responsible for my care, benefits payable to me.

I agree that, should the amount be insufficient to cover the physician's charge, I will be responsible for payment of the difference, and that if the nature of the disability be such that it is not covered by the policy, I will be responsible to the physician for payment of the entire bill, unless contractual agreements have been made between the physician and the insurance company which negate that responsibility.

Signature

Date