Insurance Assignment and Release

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is the patient covered by additional insurance? Circle Yes or No

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co _____

Group # _____

I certify that I have insurance coverage with _____ (Name of Insurer) and assign directly to Dr. _____ (Name of Doctor) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____(Name of Doctor) for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian, or Personal Representative

_____
Print Name of Beneficiary, Guardian, or Personal Representative

_____ _____
Date Relationship to Beneficiary