INSURANCE ASSIGNMENT OF BENEFITS

Patient Full Name_____ ❑ Single ❑ Married

Referring Physician:_____ PH_____ FAX_____

Street Address_____ City/State:_____ Zip_____

Work status: ❑ Currently Employed ❑ Retired ❑ Disabled (_Total or _Temporary) ❑ Student (_P/T or __F/T)

POLICY #1:

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Address (if different than patient):_____

Relationship to patient: ❑ Spouse ❑ Parent ❑ Other:_____

Employer_____ PH_____ Claim#_____

Employer address._____

POLICY #2 (if applicable)

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Declaration to Insurance Company

I hereby instruct and direct _____ insurance company to pay by check made out to the "Healthcare Provider" named below and mailed to the address below. If my current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the "Healthcare Provider" for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Conditions Required in Order for "Healthcare Provider" to Accept This Assignment

If any boxes are left unchecked, clinic reserves the right to refuse this assignment and patient must pay out-of-pocket for services.

☐ A photo copy of this assignment shall be considered as effective and valid as the original.
☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
☐ I authorize the use of this signature on all insurance claims.
☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
☐ I authorize the "Healthcare Provider named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
☐ I understand that I am financially responsible for all charges whether or not paid by insurance.
☐ This is a direct assignment of my rights and benefits under this policy.

DATE: _____/_____/20_____

Signature of Patient/Claimant_____

(If applicable) Signature of Policy Holder if not same as patient_____