

Primary Insurance Company/Address/Phone _____
Name of Policy Holder (If other than patient) _____ Birthdate of Policy
holder _____ ID # _____

Additional Insurance Company/Address/Phone _____
Name of Policy Holder (If other than patient) _____ Birthdate of Policy
holder _____ ID # _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to Dr. _____
for services rendered by him/her in person or under his/her supervision. I understand that
I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Dr. _____ to release any medical or incidental information
that may be necessary in order to carry out the treatment, payment, or health care
operations of The Center for Rheumatology, LLP.

MEDICARE/MEDICAID:

I certify that the information given by me in applying for payment is correct. I authorize
release of all records on request. I request that payment of authorized benefits be made
on my behalf.

A photocopy of these assignments shall be valid as the original.

Patient (Please print) _____
Signature _____ Date _____

Parent/Guardian (Please Print) _____
Signature _____ Date _____

Additions/Changes/Comments _____
