Assignment of Benefits

Release of information/Assignment of Benefits

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I assign all right and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider of services rendered. I understand that I will receive a monthly statement for any balance due by me.

Medicare, Medicare Replacement Plan and Medigap (Medicare Supplemental Policy Authorizations)

I request that the payment of authorized Medicare, Medicare Replacement Plan and Medigap benefits be made on my behalf to Valley Medical and Cardiac Clinic for services furnished to me by the physician. I authorize holder of medical information about me to release to Medicare, Medicare Replacement Plan and Medigap any information needed to determine these benefits payable to related services.

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for changes incurred for these services. Payment for annual deductibles and co-insurances may be collected at the time of service. I understand that I am financially responsible for the charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as deemed necessary in his/her judgment.

Patient Name:_____ Date:_____

Patient Signature:_____

Witness Name:_____

Witness Signature:_____

Note: Witness will be an office personnel when the form is turned in at the time of the appointment