Assignment of Insurance Benefits

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

Authorization to Release Information

I hereby authorize Dr. Smith / Dr. Jones to release any medical or incidental information that may be necessary for medical care or in processing of financial information.

Medicare / Medicaid

I hereby 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.

Patient (Please Print) MICKEY MOUSE MRN#:20051

Signature _____ Date 11/02/2009

MED1008