ASSIGNMENT OF INSURANCE:: I hereby authorize payment directly to the above physician of benefits due me for' the above services. I understand that I am financially responsible -For charges not covered by this assignment.

_____
Insured or guardian Signature

RELEASE OF INFORMATION:

RELEASE OF INFORMATION: I hereby authorize the above physician to furnish to insurance company all information they may request concerning my present illness or injury.

_____
Patient Signature

In some instances your private insurance company, prepaid health plan or Medicare may not pay for office visits, surgery, injections, tape-strappings, physical therapy, orthotics, etc. In such cases, please remember you are responsible for the charges that are not covered by your insurance plan. The amount paid by your insurance company is dependent on your particular insurance or medical benefit plan.

Thank you

I have read and understand the above

Patient's Signature_____ Date_____

****

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