Restorative Health Clinic

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Assignment of Benefit Form

Authorization to Release Information.

I hereby authorize Restorative Health Clinic to:

1. Release any information under the HIPA Act, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health care practitioners.
2. Release my necessary information to insurance carriers regarding my illness and treatments.
3. Process insurance claims generated in the course of examination of treatments.
4. Allow “signature on file” to be used to process insurance claims.

This order will remain in effect for up to 12 months.

I have requested medical services from Restorative Health Clinic on behalf of myself and/or dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation f the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s) to issue payments check(s) directly to Restorative Health Clinic. I understand that I am responsible for any amount at the time of service.

Patient Name: _____Date:_____

Patient Signature: _____Date:_____

Witness/Office Staff: _____ Date_____