



6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com

Assignment of Benefit Form

Authorization to Release Information.

I hereby authorize Restorative Health Clinic to:

1. Release any information under the HIPPA 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.

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 of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I understand that I am responsible for any amount due at the time of service and that the benefits of my insurance carrier will not be used as part of the payment for my services.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witness/Office Staff: _____ Date: _____



Restorative
Health Clinic

6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com



Restorative
Health Clinic

6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com