INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

_____ and assign directly to

Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or two years from the date signed below.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Please print name of Patient, Guardian or Personal Representative Relationship to Patient