Assignment of Medical Benefits other than Medicare

I request that payment of authorized insurance company benefit payment be made on my behalf to Our Family Practice for any services furnished me by the physician or practice employee. I understand that my signature authorizes payment to be made to Our Family Practice and authorizes the release of the medical information necessary to pay the claim. I understand that I will be responsible for any deductible, coinsurance, and non-covered expense.

_____ _____

Signature of Patient, Guardian, or Power of Attorney Date

Medicare Assignment of Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Our Family Practice including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. I understand that I will be responsible for any deductible, coinsurance, and non-covered expense.

_____ _____

Signature of Patient, Guardian, or Power of Attorney Date