ASSIGNMENT OF BENEFITS/RELEASE OF RECORDS/
LIMITED POWER OF ATTORNEY/PAYMENT AGREEMENT

ASSIGNMENT OF BENEFITS: **Patient Initial Here:_____**

To Insurance Company: _____ I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf for medically necessary treatment. This shall also serve as a "Limited Power of Attorney". Please provide them with any and all information regarding my policy benefits and coverage. Your denial or delay to do so in a timely manner will be considered just cause for myself, or provider to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider to file this complaint on my behalf if deemed necessary.

RELEASE OF RECORDS: **Patient Initial Here_____**

To Provider of Services: _____ at **IT&B**. I hereby authorize you to release to any attorney, physician or insurance company involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained on date ____/____/____.

PAYMENT AGREEMENT: **Patient Initial Here_____**

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including unpaid deductible and/or unpaid percentage amounts due to you according to my policy coverage, in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf.

I understand that **6 hours notice is required** for cancellation of appointments, and I will be charged for missed appointments without proper notice at 50% of the normal rate.

I understand I may elect to be billed monthly or at the time of each visit for the balances due to you from each visit. I elect to pay by Check____ Cash____ Credit Card____

SELECT ONE

1. I elect to pay the unpaid balances at the time of each visit____
2. I elect to be billed for the balance at the end of each month____
3. I elect to have outstanding bills sent to my attorney to be paid at the time of settlement if there is a settlement; if either no settlement or payment occurs, then I understand and agree that I will be responsible for payment to you for payment to you for services provided by your facility____

PATIENT'S NAME:_____

ADDRESS: _____

PATIENT'S SIGNATURE:_____ **DATE:____/____/____**

PROVIDER'S SIGNATURE:_____ **DATE:____/____/____**