

**ASSIGNMENT OF BENEFITS & RELEASE OF
INFORMATION AUTHORIZATION**

1. I AUTHORIZE PL PHYSICIANS TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED.

2. I CERTIFY THAT THE INFORMATION I HAVE REPORTED IN REGARD TO MY INSURANCE COVERAGE IS CORRECT.

3. I AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE UNDER THE TERMS OF THE INSURANCE POLICY'S COVERING (NAME OF PATIENT(S)) _____ TO BE PAID DIRECTLY TO PL PHYSICIANS FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING ANY INSURANCE CLAIMS. A COPY OF THIS ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION AUTHORIZATION MAY BE USED IN THE PLACE OF THE ORIGINAL.

4. THIS AUTHORIZATION MAY BE REVOKED IN WRITING BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME.

SIGNED: _____ DATE: _____

PAYMENT RESPONSIBILITY

1. I UNDERSTAND THAT COPAYS ARE REQUIRED AT THE TIME OF THE VISIT. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE.

2. I FURTHER AGREE, IN THE EVENT OF NON-PAYMENT, TO BEAR THE COST OF COLLECTION, AND/OR COURT COSTS AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

SIGNATURE OF RESPONSIBLE PERSON: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____