

ASSIGNMENT AND RELEASE (INSURANCE PATIENTS ONLY)

I, the undersigned, have insurance coverage with the company named above. I assign, directly to Dr. Smith, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including possible hospitalizations, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submission.

Patient Signature _____ Date _____