Capital Family Practice
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Concerning Insurance

I hereby authorize this physician to apply for benefits on my behalf for covered service rendered.

I certify that the information I have reported with regard to my insurance is correct. I further authorize the release of any necessary information, including medical information for this or any necessary claim, to my insurance carrier, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). A copy of this authorization
may be used in place of the original.

This authorization may be revoked by either me or my insurance carrier at any time in writing.

X_____ _____

Signature of patient, insured or beneficiary Date

Assignment Of Benefits

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this practice for services rendered. I further authorize the release of any information needed for processing my insurance claim(s). A copy of this authorization may be used in place of the original.

I understand and agree that I am financially responsible for charges not paid by my insurance company.

X_____ _____

Signature of patient, insured or beneficiary Date