

I hereby assign to _____ all my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, rendered by the assignee as described in the attached medical claim form.

I acknowledge that I am still responsible for paying the above referenced group if the relevant insurer, plan, or payor does not pay the physician in full at their billed amount.

Policy Name: _____ Policy Number: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- () Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- () Guardian or conservator of patient
- () Beneficiary or personal representative of deceased patient
- () Spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)