

Pulmonary and Critical Care Associates

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ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO PULMONARY AND CRITICAL CARE ASSOCIATES FOR SERVICES RENDERED BY THIS PRACTICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I AUTHORIZE THIS PRACTICE TO RELEASE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY FOR PROCESSING MY MEDICAL CLAIMS FOR PAYMENT.

PATIENT'S PRINTED NAME:

PATIENT'S SIGNATURE: _____

DATE: _____

*THIS FORM IS NOT TO BE USED FOR BILLING PURPOSES ONLY. THIS IS NOT TO BE IN PLACE OF RELEASE OF MEDICAL RECORD FORM.