



4050 Washington Rd., Rauch Bldg., McMurray, PA 15317 (412) 941-1366

A photocopy of this assignment/release shall be considered as effective and valid as the original.

#### ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this clinic, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

#### RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to any insurance company, adjustor and/or attorney involved in this case; and hereby release this clinic of any consequence thereof.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

#### FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE