



**Assignment of Benefits
&
Authorization to Release Information**

I hereby authorize payment to this clinic of all benefits specified and otherwise payable to me for any services rendered by the clinic on or after this date and for such other charges as may be made by this clinic.

I hereby agree to pay the same and also agree that in the event that payment by a third party for any individual visit exceeds that necessary to cover charges incurred during that visit, any coverage may be applied to outstanding charges owed by the clinic for other services rendered to myself, my spouse, or legal dependents of myself or spouse at the time.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or any insurance carriers all information needed for the completion of all medical claims. I understand that the information to be released may include information pertaining to mental- or psychiatric-related conditions and/or drug or alcohol abuse. A copy of this authorization shall be as valid as the original.

I certify that I have read the foregoing and am the patient or the patient's duly authorized agent to execute the above and accept its terms.

Patient Name

Signature

Witness Name

Signature

Date _____