Family Foot Health Center, P.C.

Assignment of Benefits, Release Form & Financial Policy

Patient Name:

Primary Insurance:

Policy Number: Group Number:

Subscriber Name: Date of Birth:

Subscriber Employer:

Secondary Insurance:

Policy Number: Group Number:

Subscriber Name: Date of Birth:

Subscriber Employer:

Is today's visit related to an auto accident or Workman's Comp. claim?
____YES____NO

I hereby instruct and direct the mentioned insurance companies to pay directly to:

Family Foot Health Center, P.C.
4527 Rt. 9 North
Howell, NJ 07731

<u>This is a direct assignment of my rights and benefits under this policy</u>

I understand and agree that, regardless of my insurance status, **I am ultimately responsible for the balance of my account** for any professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.

Signature Date:

Relationship (if not self):