Assignment of Benefit Authorization

Your signature is necessary for us to process to your insurance carrier all claims and to ensure payment for services rendered.

I request that payment of authorized _______________________ (Name of Insurance Carrier) benefits be made to me or on my behalf to Clinical Care Consultants, P.C. for any services furnished me by that clinic. I authorize any holder of medical information about me to release _______________________ (Name of Insurance Carrier) and its agents any information needed to determine these benefits or the benefits payable for related services.

I agree to be financially responsible for all charges. I have read this information and understand.

____	____
Print Name	Signature
____	
Client Name, if minor	
____	____
Witness Signature	Date