INSURANCE ASSIGNMENT AND RELEASE

Family First Medicine
1140 Charles Lane
Marysville Ohio 43040
Telephone: 937-578-4291

I certify that I, and/or my dependent(s), have insurance

coverage with _____.
and assign directly to Family First Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named health facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

The above named health facility may also disclose my health care information to my referring doctor and/or other doctors who will help in providing care for me. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian, or Personal Representative Date

_____ _____
Printed name of Patient, Guardian, or Personal Representative Relationship to Patient