ASSIGNMENT OF BENEFITS FORM FOR _____

(Last name, First Name)

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments. If an appointment is cancelled without 24 hrs advance notice we may charge a missed appointment fee.

ASSIGNMENT OF BENEFITS

I hereby assign all medical, surgical and dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other medical/dental plan, to issue payment check(s) directly to Practice Without Pressure, Inc. for medical or dental services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Practice Without Pressure, Inc. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical, surgical and/or dental services from Practice Without Pressure, Inc. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

FOR OFFICE USE ONLY:

Practice Without Pressure, Inc. made the following good-faith effort to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts made to obtain the individual's written acknowledgement including the reason (if known) why the written acknowledgement was not obtained.)

Last Name: _____

First Name: _____

D.O.B: _____