Assignment of Benefits / Release of Records / Payment Agreement

Part I. Assignments of Benefits
I agree to assign benefits to be paid to the provider - Tjasa Cerovsek Landes, LMT. In any circumstance whereby my insurance company does not allow for assignment of benefits, I hereby notify my insurance carrier that reimbursement check shall be made out to the provider AND myself, with check being mailed to provider's address. I hereby give limited power of attorney to my provider for sole purpose of signing my name to check for deposit only of payment for services provided to me by this provider or provider's staff or company.

This form may be submitted by fax or copies shall be valid as if it were the original. My attorney, in writing to the provider and/or the insurance company, may in the future revoke the assignment portion. Revocation of assignment will in no way release me from payment due to provider.

Patient or Authorized Person: _____ Date: _____

Signature: _____ Date: _____

Provider of Services: Tjasa Cerovsek Landes, LMT MA42365 Date: _____

Signature of Authority: _____ Date: _____

Part II. Release of Medical Records:
I hereby authorize above mentioned provider of services to release medical or any other necessary information or records, pertaining to services received by me or my dependent(s) at provider's facility, to my insurance company, physician, and/or attorney, for the purpose of billing, payment, or collection of benefits on my behalf.

Patient or Authorized Person's Signature:

Signature: _____ Date: _____

Part III. Payment Agreement:
I hereby acknowledge and understand that my provider of health care services is willing to provide insurance billing services on my behalf and for my convenience. I also understand that I am solely responsible for my medical bills and acknowledge that I shall be responsible for any unpaid balances, deductibles, and co-pays, and for any other reasonable and customary charges that my insurance company does not pay on my behalf.

I acknowledge by my signature below that I understand that my contract for insurance coverage is a contract between myself and my insurance company and has nothing to do with my provider of health care services.

Patient or Authorized Person's Signature:

_____ Date: _____