PULMONARY & CRITICAL CARE ASSOCIATES

ASSIGNMENT OF INSURANCE BENEFITS

(Please Print)

Today's date:	
Name:	Date of Birth:

ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____ to pay and
(Name of Insured) (Name of Insurance Company)

hereby assign directly to Pulmonary & Critical Care Associates all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid you Pulmonary & Critical Care Associates will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)