INSURANCE ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to First Care Medical Clinic for any services rendered. All regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder to release all medical or other information about me to the Health Care Financing Administration and its agents needed for this claim or related claims. I further authorize any holder to release all medical or other information about me to any other insurance company for this claim or related claims.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to First Care Medical Clinic who accepts assignment. I understand that I am ultimately responsible for all medical expenses incurred regardless of my insurance coverage. This includes, but is not limited to co-pays, deductibles, and "usual, customary and reasonable fees" not paid by my insurance company.

Name:_____

Street Address:_____

City/State/Zip Code:_____

Day Time Phone Number:_____

Medicare #:_____

Medigap #:_____

Insured ID #_____

Patient/Insured Signature_____ Date:_____