



CONSENT FORM – ASSIGNMENT OF BENEFITS & DIRECT BILLING AUTHORIZATION

Patient Information

Full Name: _____

Date of Birth: _____

Insurance Provider: _____

Policy/ID Number: _____

1. Assignment of Benefits

I, the undersigned patient (or legal guardian), hereby authorize and direct my insurance company to pay benefits for eligible healthcare services provided by the above-named healthcare provider directly to the provider.

I understand that this assignment applies to all claims submitted for services rendered and remains valid until revoked in writing by me.

2. Direct Billing Authorization

I authorize the healthcare provider to submit claims on my behalf to my insurance company for direct payment of covered services.

I also authorize my insurance company to release any necessary information to the provider for the purpose of processing claims, determining benefits, and coordinating payment.

3. Financial Responsibility

I understand that I am responsible for:

- Any charges not covered by my insurance plan
- Deductibles, co-payments, and co-insurance amounts
- Any services deemed ineligible or denied by my insurance provider

4. Release of Information

I authorize the release of medical and/or billing information necessary for insurance processing, claims submission, and payment reconciliation.

5. Consent & Acknowledgment

I acknowledge that I have read and fully understand this agreement. I voluntarily authorize assignment of benefits and direct billing as described above.

Patient/Guardian Signature: _____

Date: _____

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