

**Center for Hand & Extremity Reconstructive Surgery, PLC**

**Assignment of Benefits & Authorization to Release Information**

I hereby authorize \_\_\_\_\_  
(Name of Your Insurance Company)

To pay directly the Center for Hand & Extremity Reconstructive Surgery, PLC all benefits due me, if any by reason of services described in the statements rendered, and as provided for in the above policy contract with the aforementioned insurance company, but not to exceed by indebtedness to said clinic. I will pay for all such charges incurred or for all charges in excess of whatever sums may be paid by the insurance company mentioned above.

I direct that medical benefits (if any) be paid to the Center for Hand & Extremity Reconstructive Surgery, PLC.

I authorize the Center for Hand & Extremity Reconstructive Surgery, PLC to release medical information to any insurance company with whom I have filed a claim; to any governmental agency with which I have applied for benefits; to any physician for which I have requested; to any attorney who I retain to represent me.

Although I may be represented by an attorney on matters related to illness or injury for which the Center for Hand & Extremity Reconstructive Surgery, PLC had rendered services to me, I must keep my account current and paid in full. If my account becomes delinquent and is referred to an attorney or collection agency, I agree to pay all attorney or collection fees, all court costs incurred by the Center for Hand & Extremity Reconstructive Surgery, PLC in addition to the outstanding balance of the account.

This agreement is in addition to any other agreement which I may have with the Center for Hand & Extremity Reconstructive Surgery, PLC. I have read this document, understand it fully, and agree to the terms and conditions specified herewith.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_