INSURANCE RELEASE

I hereby authorize release of any information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance plan.

☐ **I have CONTACTED my insurance company and I am aware of my benefits:**

Signature: _____ Date: _____

☐ **I have chosen NOT TO CONTACT my insurance company, but I am aware that it is my responsibility to contact my insurance company with any questions regarding benefits:**

Signature: _____ Date: _____