

Letter of Assignment
Evan D. O'Brien, M.D., P.C.

Name: _____ Date of Birth: _____

1) I authorize direct payment of medical benefits to Evan D. O'Brien, MD, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance, including, but not limited to, co-payment and deductible amounts. In addition, if my insurance plan requires a co-payment for services provided, I will pay such a co-payment *at the time services are rendered*.

INITIALS: _____

2) I authorize Evan D. O'Brien, MD, P.C. to release any medical or incidental information that may be necessary for medical care or for processing applications for financial benefit.

INITIALS: _____

3) I certify that the insurance information that I have provided is correct and complete. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

INITIALS: _____

4) I also authorize the release of any and all medical records and films from any and all other facilities or physicians that are needed for my medical care.

INITIALS: _____

5) A photocopy of these assignments shall be valid as the original.

Patient Signature: _____

Date: _____

Patient's guardian (if patient under 18): _____

Date: _____