Authorization

Assignment of Benefits

I authorize _____ insurance company to you pay **Biocore Health** all insurance benefits due to me for services rendered.

I authorize the use of this signature on all insurance submissions, **including** all insurance submissions for family members for whom I am the insured party.

I authorize **Biocore Health** to release any information necessary to my insurance company in order to secure the payment of benefits.

I understand that I am financially responsible for all charges incurred in this office, whether or not covered by my insurance company.

_____ _____

Print Patient Name Date

_____ _____

PATIENT Signature (or legal Guardian) Relationship if Guardian

Note

On occasion, insurance companies will send payment to the patients instead of the doctor.

Should this happen, I agree to NOT cash the check, contact the office, and bring all paperwork with the check to the office.

I understand that I am liable for any monies erroneously sent to me by the insurance company.

_____ _____

Signature Date