ASSIGNMENT OF BENEFITS:

I request that payment of insurance benefits be made either to me or on my behalf to Phoenix Medical Group, P.C. for any services furnished me by or in Phoenix Medical Group, P.C. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or benefits for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature: ____

MEDICARE BENEFICIARY:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Phoenix Medical Group, P.C. for any services furnished me by or in Phoenix Medical Group, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature: ____

HICN: __________________________

MEDIGAP AUTHORIZATION (Medicare Supplementary Insurance):

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Phoenix Medical Group, P.C. for any services furnished me by that practice. I authorize any holder of medical information about me to release to Phoenix Medical Group, P.C. any information needed to determine these benefits or the benefits payable for related service. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature: ____

HICN: __________________________ Policy Number: __________________________