

# Assignment of Insurance Benefits

I hereby represent and agree as follows:

1. Medical care has been or will be provided to me or my dependent (patient whose name appears below)
2. I represent that I presently maintain medical insurance coverage which will reimburse the charges for the medical care provided.
3. I hereby authorize the physicians of Kaner Medical Group, P.A. to release information requested by my insurance company to process payment for medical services rendered.
4. I understand I am financially responsible to Kaner Medical Group, P.A. for charges not reimbursed by my insurance plan.

In consideration of these medical services, I hereby assign, transfer and set over to Kaner Medical Group, P.A. all of my rights, title and interest to medical and physician reimbursement benefits under my insurance policy as indicated below. If my insurance benefits are provided through an IRISA plan, I hereby assign, transfer, and set over all of my right, title and interest as a beneficiary of the ERISA plan to Kaner Medical Group, P.A., with regards to my treatment and care.

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Signature of Insured