Print Form

SPECTRUM **Prosthetics & Orthotics of Redding, Inc.**

Assignments of/and Authorization to Pay Medical Expense Benefits

Patient Name: _____

Subscribers Name: _____ DOB: _____

Insurance Company: _____

I hereby direct you to pay Spectrum Prosthetics & Orthotics of Redding, Inc. all basic and major expense benefits. I understand that I am responsible for any balance.

I authorize Spectrum Prosthetics & Orthotics of Redding, Inc. to release any medical information necessary to determine these benefits.

If policy specifically prohibits assignment, make check payable to BOTH subscriber and Spectrum Prosthetics & Orthotics of Redding, Inc. and send directly to the company.

NOTE: Payment by an obligator to a person other than the assignee after notification of assignment may result in liability to the obligator to repay the amount paid.

I understand that the entire amount of the fees for your services and/or appliance is my personal responsibility, even though this may or may not be covered by insurance. If you bill the insurance company direct, I understand that I am to pay my portion of the bill when your service has been rendered.

Signed: _____ Date: _____