

Insurance Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to Dr. Davidson all insurance benefits, if an, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services. This centent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, medigap benefits, be made either to me or on my behalf to Dr. Davidson for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to be released to the Centers for Medicare and Medicaid Services, my medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or personal Representative

Please print name of Beneficiary, Guardian of personal Representative

Date