MIDLAND COUNTY HEALTH DEPARTMENT
220 W ELLSWORTH ST
MIDLAND MI 48640

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS

Patient Name: _____ Date _____

In considering the amount of expenses to be incurred, I _____, the undersigned, have insurance and/or employee health care benefits coverage with _____(insurance co. information), and hereby assign and convey directly to Midland County Health Department. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by my insurance company for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. All payments will be made to provider and practice at Midland County Health Department.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

The assignment will remain in effect until revoked in writing. A scanned/photocopy of this assignment of benefits is to be considered as valid as the original.

Please be aware that if you are on your parent's insurance plan they will receive an explanation of benefits for any services done at the Health Department. If you are opposed to this, you will not need to sign this form as we will not bill your insurance plan.

The terms and consequences of this assignment and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

NAME of Insured / Responsible Party	Signature of Insured / Responsible Party	Date

NAME of Patient or Guardian	Signature of Patient or Guardian	Signature of WITNESS