Assignment of Insurance Benefits

I hereby assign to IPP all money to which I am entitled for medical expenses related to the services performed by IPP, but not to exceed my indebtedness to IPP. I authorize IPP to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims.

I understand that failure to pay outstanding balances with 90 days of notification of the amount due may result in further collection action.

Patient(print)_____

Patient(sign)_____

Parent/guardian(print)_____

Parent/guardian(sign)_____

Date_____

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to IPP. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient(print)_____

Patient(sign)_____

Parent/guardian(print)_____

Parent/guardian(sign)_____

Date_____