Little Traverse Primary Care
Assignment of Benefits

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage and assign Little Traverse Primary Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance and liability/work compensation/auto claim submissions.

Patient/Guardian Signature: _____

Today's Date: _____

Print Patient Name: _____

Patient Birthdate: _____