Please complete the form online,
print and sign, then fax or bring the form to your office visit.

EFFECTIVE FEBRUARY 2, 2006

ASSIGNMENT AND RELEASE

We agree to submit a claim to your insurance company based on the information you have provided to us.
You agree to accept responsibility for co-payments, deductibles, co-insurances, medical care and other services that are provided to you which are not specifically covered by your health care for any reason, i.e. a failure on your part to obtain necessary authorizations or appropriate referrals. Other examples include refusals by your insurance company to pay benefits because of circumstances which preclude coverage, i.e. injuries on the job (worker's compensation), injuries sustained by motor vehicles (no-fault) or pre-existing conditions.
This agreement is not intended to conflict with or circumvent the provisions of contracts and governmental regulations.
This agreement is not intended to conflict with any grievance procedure that maybe available to you.
In providing credit card information below, you authorize payment by credit card for any uncovered or partially covered services.

Name as it appears on credit card:_____

Credit card type:_____

Credit card number:_____

Expiration Date:_____

Zip code of billing address:_____

I hereby authorize payment directly to Paul E. Hammerschlag, M.D., F.A.C.S.

Signature:_____