Chan Soon-Shiong Medical Center at Windber

Orthopedic Walk-In Clinic

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Orthopedic Walk-In Clinic, 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 authorize the use of my signature on all insurance submissions. The above named provider 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 and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed of one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Representative **Date**

_____ _____
Print name of Patient, Parent, Guardian or Representative **Relationship to Patient**