**ASSIGNMENT OF BENEFITS**

Date: _______________

Client: ____________________________________________________

Ins. Co.: __________________________________________________

__________________________________________________

__________________________________________________

I hereby authorize payment directly to the above named provider for all professional benefits payable to me but not to exceed the regular treatment and/or fees for this period of professional treatment and/or services. I do understand that I am financially responsible for any amounts that are not paid through my insurance company.

Signed: __________________________________________________

Witness: __________________________________________________

Suscriber (if other than client): ________________________________