



Assignment and Release

With Insurance

I, _____ the undersigned certify that I (or my dependent) have insurance coverage with _____ (Insurance Company) and hereby assign/ transfer and set over to Alpha Primary Healthcare all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that full payment (including co-payment) is expected at time of service. I hereby authorize Alpha Primary Healthcare to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____

Relationship _____ Date _____

Without Insurance

I, _____ the undersigned certify that I (or my dependent) do not have insurance coverage with any company. I understand that I am responsible for all charges. I understand that full payment is expected at time of service. I understand my responsibility and acknowledge it by signature on this form.

Signature of Responsible Party _____

Relationship _____ Date _____

Acknowledgment of Receipt

I, _____ have received a copy of Alpha Primary Healthcare's Office Policy and Notice of Privacy Practices.

Signature of Responsible Party _____

Relationship _____ Date _____