Assignment of Benefits, Medical Release, and Financial Responsibility

Medical Information Release Authorization

I authorize Mighty Oaks Children's Therapy Center to release my child's personal health information to insurance companies and healthcare professionals for the purposes of treatment, payment and other healthcare related options.

Assignment of Benefits & Financial Responsibility Consent

I request that any payment of authorized insurance benefits be made directly to Mighty Oaks Children's Therapy Center.

I further agree to assume financial responsibility for all claims due to Mighty Oaks Children's Therapy

Center for therapy not paid by my insurance, including but not limited to, deductibles and co-pays. If my primary, secondary and/or tertiary insurance coverage changes or if payment/coverage is denied, I understand that I am financially responsible for any amount not covered.

Patient Name ______________________ Date: ______________

Signature: ______________________ Relationship to Patient: ______________

Primary Insurance Information

Insurance Company Name	
Policy Holder's Name	
Member ID Number	
Group Number	

Secondary Insurance Information

Insurance Company Name	
Policy Holder's Name	
Member ID Number	
Group Number	