Date: _____
Patient's Full Name: _____
Cell phone: _____
E-Mail Address: _____
Date of Birth: _____
Social Security #: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of Perez Family Health Center (hereafter referred to as **PFHC)** undertaking to care for me, I agree to the following:

1. I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Elizabeth Perez (DBA Perez Family Health Center) **all** insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if not covered or paid by my insurance. If I **DO NOT** have or provide insurance, I agree to pay all charges and fees associated with my treatments.
2. Perez Family Health Center from here on as PFHC is authorized to release **any information** deemed appropriate or necessary. I authorize the use of my signature on all insurance submissions.
3. I authorize the direct payment to PFHC of any sum I now or hereafter owe to PFHC by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or PFHC based in whole or in part upon the charges from PFHC.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to PFHC for the charges made for services provided by PFHC **refuses to make such payment** upon demand by PFHC, I hereby assign and transfer to PFHC the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize PFHC to prosecute said action either in my name as you see fit and further authorize PFHC to compromise, settle, or otherwise resolve said claim. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated; PFHC will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts not collected from insurance companies proceeds, whether it be all or part of what was due, I personally owe PFHC.
5. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the state of Missouri and give my consent to PFHC to add any applicable collection fees to my account if not paid promptly.
6. I further agree that this Authorization and Assignment is irrevocable until all money owed Perez Family Health Center are paid in full.

Patient Signature: _____ Date: _____