Assignment of Benefits and Release of Information

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

_____

Name of Insurance Company (ies)

and assign directly to Bruce Kaster, M.D., all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially liable for all charges whether or not paid by insurance.

Further, if my health insurance provider determines that services are not covered, I will be responsible for the full fees charged by the physician. I authorized the use of my signature on all insurance submissions.

Bruce Kaster, M.D., may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents or the benefits payable for the related services.

_____

Signature of Patient or Legal Guardian Date

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Please Print Name of Patient or Legal Guardian Date