ASSIGNMENT OF BENEFITS

Name of Patient: _____

Date of Accident/Injury:_____

Release of information, assignment of benefits and out-of-network contract:

I authorize *FedCare and/or The Broadway Clinic* to release any information regarding any illness/injury to all involved insurance companies and/or my attorney in regards to the above injury.

I also authorize all involved insurance companies and/or my attorney to pay directly to *FedCare and/or The Broadway Clinic* all medical benefits pertaining to services rendered by this clinic, if any, otherwise payable to me.

If my current insurance policy prohibits direct payment to my physician, then I hereby instruct and direct my insurance carrier to make out any benefit check payable to me and mail as follows:

FedCare and/or The Broadway Clinic
P.O. Box 152
Oklahoma City, OK 73101

I understand that charges which are not paid by the insurance are my responsibility. I understand that my credit report may be obtained to assist *FedCare and/or The Broadway Clinic* in any collection efforts.

I understand that if I have health insurance in force during my treatment for this injury, I am contracting outside of my network for any treatment received relating to this injury. Any network discounts or write-off's will not apply for any treatment related to this injury. I understand that *FedCare and/or The Broadway Clinic* will not file to my health insurance for services rendered relating to this accident, UNLESS it becomes the only source of payment; at which time I am still ultimately responsible for any balance not paid by any other source.

I ALSO HAVE BEEN INFORMED AND UNDERSTAND THAT FEDCARE AND THE BROADWAY CLINIC DO NOT ACCEPT MEDICARE OR MEDICAID INSURANCE.

A copy of the above is considered as valid as the original copy.

Signature: _____ Date:_____