ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims submitted on behalf of myself or dependents. I acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or a service to be rendered and that will be bound by this signature as though the undersigned had personally signed this particular claim. I, _____, hereby authorize _____
(Print name of Insurance Comp)
To pay and hereby assign directly to Dr. Collette Ara-Honore all benefits, if any, Otherwise payable to charges incurred. I understand that I am financially responsible for all charges whether or not paid by my insurance. Balances older than 60 days will be subject to a finance charge of $30.00 _____ (Initial). If the account goes to a collection agency, Dr. Ara-Honore will charge a fee no less then 35% of the total balance due in addition to any legal fees that may be incurred in an effort to get reimbursed.

_____ _____
(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)