

EL Paso Child Neurology, PA

Miguel A. Moreno, MD

1900 N Oregon St., Ste 206 El Paso TX 79902

**Assignment of Benefits**

**And**

**Release of Information**

I hereby assign to El Paso Child Neurology all my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical rendered by the assignee. Necessary forms will be completed to file for insurance payments.

I acknowledge that I am still responsible for paying the above referenced group if the relevant insurer, plan, or payor does not pay the physician in full at their billed amount.

I have requested medical services from Dr. Miguel A. Moreno on behalf of myself and/or my dependents and I hereby authorize Dr. Miguel A. Moreno to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Please make note that it is your responsibility to inform our office of any changes regarding your health plan.

Policy Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_