Venice Spine & Disc **Assignment of Benefits** Dr. Michael Grocholski, D.C.

153 Center Rd.
Venice, Florida 34285
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Directive of Payment:
Personal Injury, Medicare, and Insurance Assignment of Benefits:
Authorization and Signature on File:

Re: _____(patient)
Medicare ID: _____
Insurance ID: _____
PIP Claim No:_____

1) I authorize provider ***Drs. Grocholski***; to use my name on any and all forms or documents which relate to Medicare, Personal Injury Protection (auto PIP), and all other health insurance benefits which relate to me and my dependents.
2) I authorize the release of information related to any claims to my Personal Injury, Medicare, and all Insurance companies or other relevant parties.
3) I understand that ***I am responsible for all charges*** and agree to pay for all services provided to me ***that are not covered by PIP, Medicare or other insurances***.
4) I authorize ***Dr. Grocholski and staff*** to act as my agents in helping me obtain from PIP, Medicare and/or my Insurance companies.
5) I assign and authorize payment of PIP, Medicare, and Insurance health benefits related to services rendered in this office otherwise payable to me, directly to provider, ***Dr. Grocholski***.
6) I ***assign payment directly to provider Dr. Grocholski*** all Personal Injury, Medicare and all other insurance benefits for services rendered in this office.
7) I authorize and permit a copy of my signature on this ***Authorization and Signature on File*** to be used in place of the original on all insurance submissions.
8) I authorize and demand that ***Dr. Grocholski*** file an appeal to Insurance companies on my behalf if necessary.

Consent of Treatment:

I voluntarily consent to the rendering of care; including the performance of diagnostic procedures. I understand that I am under the care and supervision of ***Dr. Grocholski, DC*** and it is the responsibility of the staff to carry out the instructions of ***Dr. Grocholski.***

Signed:_____; ***Date:***_____;
Printed Name:_____; ***Relationship:***_____;

Witness:_____.