# WILLIAM R. MORGAN, D.C.
# STUART, FL 33497
# (772) 515-1134 Tax ID 65-0696518

## Patient Name:_____

**Assignment Of Insurance Benefits:**

**I hereby authorize payment to be made directly to *WILLIAM R. MORGAN, D.C.*, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to *WILLIAM R. MORGAN, D.C.***

**Furthermore, I hereby IRREVOCABLY ASSIGN to *WILLIAM R. MORGAN, D.C* the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by *WILLIAM R. MORGAN, D.C.***

**Authorization To Release Medical Record Information:**

***WILLIAM R. MORGAN, D.C* is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by *WILLIAM R. MORGAN, D.C.* This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said *WILLIAM R. MORGAN, D.C.***

**The undersigned certifies that He / She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.**

**Signature of witness:_____ Date:_____**

**Signature of patient or responsible party_____ Date: _____**