ARIZONA ALLERGY ASSOCIATES

BENEFIT ASSIGNMENT

(1) I hereby assign my insurance benefits to be paid directly to the physicians or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make the check payable to Arizona Allergy Associates and me.

(2) I authorize the physician to deposit checks received on the patient's account when made out to the patient.

(3) I authorize the physician to release any information required to process claims or required in the course of my exam and treatment.

(4) I hereby agree to pay my account as services are provided. If for any reason a balance is owed on my account, I agree to pay promptly upon receipt of the monthly statement.

By signing this document, I state that all information given is accurate and current. If my insurance denies payment, I understand that I am financially responsible for charges.

Signature	Name of Patient	Relationship to Patient
Printed Name	Date of Birth of Patient	Date form signed
AAA Witness Signature	Date	Witness Printed