

COMPREHENSIVE WOMEN'S HEALTHCARE, P .A.  
OB INSURANCE INFORMATION

Patient Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ SS# \_\_\_\_\_

Insured Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employers Address: \_\_\_\_\_

Insurance **Company**: \_\_\_\_\_ Insurance Phone \_\_\_\_\_

**Insurance** Address: \_\_\_\_\_

I.D./Policy#: \_\_\_\_\_ Group # \_\_\_\_\_

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY; In consideration of services rendered, I hereby irrevocably assign and transfer to Comprehensive Women's Healthcare, P.A., all rights, title and interest in the benefits payable for services rendered by said clinic provided on the above mentioned policy of insurance. I hereby authorize the Insurance Company herein listed above to pay directly to Comprehensive Women's Healthcare, P .A. Comprehensive Women's Healthcare, P .A. is authorized to release to any insurance company having coverage on me (or to the employer if coverage is under a group plan) any of my medical records pertaining to this medical claim. A photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_