

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO
THE INSURANCE CARRIER
AND
ASSIGNMENT OF BENEFITS TO PROVIDER**

Swiss Balance Inc. agrees to submit charge(s) and any required documentation to my insurance carrier for payment on my behalf. I hereby authorize the release of any information necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to:

Swiss Balance Prosthetics Orthotics Pedorthics

as payment toward the total charges for the product(s)/service(s) rendered.

I understand that I am ultimately responsible for the deductible, copayment, and any charges not covered by my insurance carrier.

I authorize Swiss Balance Inc. to initiate a complaint to the Insurance Commissioner for any delayed or improperly processed claims on my behalf.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Date: ____ / ____ / ____

Signature _____
(If the patient is a minor, parent or legal guardian must sign)

Print Name _____