Capital Internal Medicine Associates P.C.
3955 Patient Care Dr
Suite A
Lansing Mi 48911

ASSIGNMENT OF BENEFITS

Patient Name_________________________ Acct.#_____________________

I hereby give lifetime authorization, to be withdrawn only in writing submitted to the address above, for payment of Insurance benefits to be made directly to Capital Internal Medicine Associates P.C.. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I agree to pay all costs associated with trying to collect any debt owed by me in the event of default. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_________________________________ _________________________________
Patients Signature Date

3955 Patient Care Dr.
Lansing MI 48911
517-374-7600

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