



WE'VE GOT YOUR BACK!

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Edmonds Massage Center Assignment of Benefits & Release of Records

ASSIGNMENT OF BENEFITS

_____ (Please fill in insurance co. name), I hereby direct and instruct you to make payment directly to the undersigned provider for medical claims submitted by them on my behalf for medically necessary treatment.

Your denial or delay to do so in a timely manner will be considered just cause for myself or provider to file a complaint with the Washington State Insurance Commissioner. I hereby give my permission to the undersigned provider to file this complaint on my behalf if I deem necessary.

RELEASE OF RECORDS

I hereby authorize Edmonds Massage Center to release to any attorney, physician or insurance company involved in my case, any information or records contained in my medical file at Edmonds Massage Center, necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury / illness sustained on ___/___/___.(date)

CLIENT NAME

CLIENT SIGNATURE

DATE