

Roy M. Rubin, M.D.
500 University Ave, Ste 100
Sacramento, CA 95825
916-452-1900

"I, the undersigned, have insurance coverage with _____ (name of insurance company) and assign directly to Dr. Roy M. Rubin, all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I also understand that I will be charged and responsible for a 15% or \$20.00 late penalty fee, whichever is greater, on any portion of the charges that are my responsibility that have not been paid after 42 days. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions

_____ (signature) _____ (date)

Relationship to patient _____

Authorization to Release Information:

I authorize any holder of medical information about me to release information to any of the following: My insurance company, the social security administration and/or medicare program or its intermediaries or carriers, and/or the professional review organization. This authorization covers any information needed for processing and payment of insurance claims. This is a life time authorization.

_____ (signature) _____ (date)