Authorization of Assignment

To: MICHAEL J. WHITELEY D.O. / D.B.A. TOMBALL FAMILICARE

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical or mental condition to any insurance company, attorney or adjuster in order to process any insurance claim for reimbursement of charges incurred by me as a result of medical services rendered by you or your staff, and I hereby release you of any consequences thereof.

On Site Inspection Release

I authorize my Insurance Company Representative to review information contained in my medical records for their routine inspections.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to MICHAEL J. WHITELEY D.O., D.B.A. TOMBALL FAMILICARE, I hereby assign and transfer to MICHAEL J. WHITELEY D.O. the cause of action that exits in my favor against any such company, and authorize you to prosecute said action either in my name or your name as you see fit, and further authorize you to compromise, settle or otherwise resolve said claim as you see fit.

Authorization to Pay Directly to the Doctor

I authorize and direct my insurance company to make payment to the doctor name above any sum I may now or hereafter owe him. I agree to pay any and all applicable deductibles, and co-pays. I further agree to pay my balance if my insurance company has not paid within 120 days of the date of service.

Date: _____

_____

Signature of Patient/Guardian