ASSIGNMENT AND RELEASE OF BENEFITS:

- I hereby assign my insurance benefits to be paid directly to Community Care of West Virginia, Inc.
- I consent to any services rendered to me or to my dependents under a provider's orders.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance as specified on the Financial Agreement.
- I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize Community Care of West Virginia, Inc. to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A fee for no shows may apply.
- The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Signature: _____

Patient Date of Birth: _____

Date: _____