



**HEALTH INSURANCE
ASSIGNMENT OF BENEFITS**

Insurance Company _____ Policy No. _____
Address _____ Phone _____
Name of Policy Holder _____ SS# _____
Name of Patient _____ SS# _____
Relationship to Policy Holder _____
Employer (if Group Insurance) _____

I hereby direct the above insurance company to pay to InterPlay, Inc. all medical benefits due me under policy for covered expenses rendered to the patient identified above. Please make check payable to: InterPlay, Inc. and mail to:

14552 Larkspur Lane
Wellington, FL 33414

I understand that this authorization applies to those eligible charges submitted in connection with services or supplies furnished only by and through the above provider. In addition, I understand that I am responsible for any portion of charges, including any attorney's fees, interest on unpaid balances and all costs of collection resulting from any investigation necessary to collect this claim, not reimbursed through other sources.

**** INSURANCE COMPANY – IMPORTANT- PLEASE NOTE ****

Your insured, whose name and signature appear below, has by this Assignment directed you to make payment of all benefits for services provided by InterPlay, Inc. directly to InterPlay, Inc. Should you fail to make payments in accordance with this written Assignment, you will not have discharged yourself from liability under the policy identified above, and your remaining obligation to InterPlay, Inc., to the extent that you have violated the terms of this Assignment, may result in you becoming legally obligated to pay the same benefits twice.

Signature of Policy Holder

Date

Witness

Date