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ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled to Guo's Medical Clinic, LLC. I further authorize Guo's Medical Clinic, LLC to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to Guo's Medical Clinic, LLC, or to the party who accepts assignment.

I certify that information I have provided with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

AUTHORIZATION TO RELEASE INFORMATION
CONSENT TO TREAT

I authorize Guo's Medical Clinic, LLC to release any medical information necessary for either my medical care, or for application of my financial benefit. I permit a copy of this authorization to be used in place of the origin. I also give Guo's Medical Clinic permission to treat for my medical conditions.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company. I hereby authorize to release all information necessary to secure the payment.

Signature: _____ Date: _____

RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of Guo's Medical Clinic LLC's HIPPA Notice of Privacy Practices. I understand that I have the right to review the privacy notice, and to request restrictions and revoke consent in writing after I have reviewed the privacy notice.

Signature: _____ Date: _____