Chart Number: _____________

Assignment of Benefits Form

I hereby authorize my insurance benefits to be paid directly to CHAPA-DE INDIAN HEALTH PROGRAM, INC. I am financially responsible for non-covered services. I also authorize CHAPA-DE to release to my insurance company, Medicare or Medi-Cal any information required to process this claim (including information relating to alcohol, drug abuse and mental/nervous disorders).

I authorize Chapa-De Indian Health Program, Inc. to provide medical, dental, and/or behavioral health care to the minor named below as a patient or to myself. I have read and understand the Patient Bill of Rights.

Patient's Name: ____

Signature: ___________________________________ Date: ____________________
Patient/Guardian/Authorized Representative

Relationship: ____