ASSIGNMENT AND RELEASE:

I, the undersigned, have insurance coverage with _____,
Name(s) of Insurance(s)
and assign directly to Dr. Edred V. Shen all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Shen to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature Date

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or to my behalf to Dr. Edred V. Shen for any services furnished me by him. I authorize that any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or that benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare awarded cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as XXX charge, and the patient is responsible only for the deductable, coinsurance, and uncovered services. Coinsurance and the deductable are based upon the charge determination of the Medicare carrier. Medicare will only pay for services that it determines "responsible and necessary" under Section 1862 (a) (1) of Medicare law. Medicare will not pay for acupuncture (Procedure Codes 97780 and 97781) Medicare must be billed if my secondary insurance pays for this service. This authorization will expire 2 years from signing.

I, _____, understand the above.
Name (Please Print)

_____ _____
Signature Date