



Assignment of Insurance Benefits

I hereby authorize direct payment of surgical and/or medical benefits to Dr. Debora Sedaghat, D.O., for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance(s) not covered by my insurance . I further agree, in the event of non-payment, to bear the cost of reasonable legal fees, should this be required

Patient Signature or Legal Guardian

Date

Print Patient Name