Family Practice Associates
a professional corporation

EUGENE D. POGORELEC, D.O.
M. TERRANCE SIMON, D.O.
WAYNE H. LUTZKE, D.O.

ASSIGNMENT FORM

I HEREBY AUTHORIZE AND DIRECT (MY ATTORNEY AND/OR INSURANCE COMPANY) _____
TO MAKE PAYMENT TO:

FAMILY PRACTICE ASSOCIATES, INC.
2300 WALES AVENUE NW
SUITE 100
MASSILLON, OH 44646

FOR MEDICAL BENEFITS, OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED INDEBTEDNESS TO FAMILY PRACTICE ASSOCIATES, INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SAID PHYSICIAN(S) FOR CHARGES NOT COVERED BY THIS AUTHORIZATION. I ALSO UNDERSTAND THAT MY PERSONAL HEALTH INSURANCE WILL NOT BE BILLED FOR THESE SERVICES.

SIGNATURE: _____

ADDRESS: _____

_____

_____

_____

DATE: _____

WITNESS: _____

2300 Wales Avenue, N.W.
Massillon, OH 44646
Ph: (330) 8323188
Fax: (330) 832-9936