Pacific Center for Naturopathic Medicine

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Rachelle Herdman, M.D.(Britain), N.D.
MEDICAL DIRECTOR

ASSIGNMENT OF BENEFITS FORM

TO THE PATIENT:

Please fill out this form. The completed form will ensure that payment for your health care services will be sent directly to your health care provider. This authorization will be kept as a permanent part of your medical record.

NAME:_____
(please print)

I hereby authorize RACHELLE B. HERDMAN, N.D. to furnish my health insurance company all the information which said insurance payer may request concerning treatment for myself.

I hereby assign RACHELLE B. HERDMAN, N.D. the medical benefits to which I am entitled under my health insurance plan.

Signature:_____

Date:_____