



IF YOU WILL BE USING INSURANCE BENEFITS THAT COVER SERVICES, PLEASE COMPLETE AND SIGN BELOW:

Insurance Co. _____ Named of insured: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Grp./Policy #: _____ Medicare Y ___ N ___ Medicare #: _____ Retirement date: _____

I hereby instruct the _____ Insurance Co. to pay by check made out to and mailed directly to:

**SOUTHERN CALIFORNIA UNIVERSITY OF HEALTH SCIENCES
16200 E. AMBER VALLEY DR., WHITTIER, CA 90604**

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

**SOUTHERN CALIFORNIA UNIVERSITY OF HEALTH SCIENCES
16200 E. AMBER VALLEY DR., WHITTIER, CA 90604**

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance and/or Co-pay of said professional service charges over and above this insurance payment.

I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Southern California University of Health Sciences and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case.

DATE: _____ 20 _____ SIGNED: _____ (Patient or Insured)

IF YOU DO NOT HAVE INSURANCE THAT COVERS SERVICES, PLEASE READ AND SIGN BELOW:

I hereby acknowledge that I have no insurance that covers services, and I understand that all services are payable when treatment is rendered.

I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Southern California University of Health Sciences and any emergency transporting that may be required thereto.

DATE: _____ 20 _____ SIGNED: _____ (Patient, Parent/Guardian)

ARE YOU AN SCUHS: Student _____ Employee ___ Alumni ___?

Student Family ___ Employee Family ___ Alumni Family ___?

If a family member, name of the student, employee or alumni: _____