Michael Odibo, M.D.
Odibo Medical Group
1099 Medical Center Drive, Suite 100-A
Wilmington, North Carolina 28401
office.odibomedicalgroup@gmail.com
Phone (910) 228-5894 | Fax (910) 228-5897

AUTHORIZATION/ASSIGNMENT OF BENEFITS

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance carriers.
- I understand that **I** am responsible for my bill.
- I authorize my doctor to act as my agent in assisting me to obtain payment from my insurance carriers.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

INSURANCE:

We will assist you in filing claims in every reasonable way possible, but please remember that your insurance represents a contract between **you (or your employer) and a health insurance company**. We will always look to you in our dealings with your insurance carrier, and ask you to deal directly with your insurance company in the event of disputes with your insurance carrier.

Please be sure to provide us with complete details regarding your coverage and filing requirements. At future appointments, **please notify us of any changes**. Your cooperation is necessary to ensure payment for services rendered is made by your insurance company to Odibo Medical Group.

We will do everything possible to ensure that you receive full benefits from your insurance policy. However, **if your insurance company has not paid their portion within sixty (60) days from the start of treatment, you become responsible for payment of your account.** Any balance remaining after your insurance company has paid its portion will be billed to you and due within thirty (30) days.

Patient Name (Printed):____

Patient Signature:____
(or responsible party)

Date:____