Roxann Sangiacomo, M.D., PA
Adult Psychiatry

Patient's Name_____ DOB:_____

Authorization to pay benefits: I/we hereby authorize and request payment directly to **Roxann M. Sangiacomo, M.D., PA** or any other doctor (s) (who will be seeing me/my dependent on an on-going basis), including CHAMPUS, or any other government oriented insurance, of the benefits, if any, otherwise payable to me/us. This assignment shall remain in full force and effect until written notice to the contrary is provided by the undersigned (s), or until said account is paid in full. I/we acknowledge that I/we will, each, be personally responsible for payment of assigned insurance benefits when not paid within sixty (60) days of filing a completed claim; or when adequate information to determine whether the insurance will pay the charges is unavailable; or when/if the insurance company should refuse to pay benefits, for whatever reason, unless written negotiations have taken place between the said doctor's office and myself/ourselves.

_____ _____
Insured's Name (Primary Insurance) Date

_____ _____
Insured's Name (Secondary Insurance) Date