South Shore Cosmetic Surgeons, LLC
36 Lincoln Ave
Rockville Centre, NY 11570

Assignment of Benefits Form

Name of Insured (print): _____

I authorize Dr. Hassan/Dr. Waheed to submit to my insurance company on my behalf, and that **MY INSURANCE COMPANY PAY BENEFITS DIRECTLY TO DR. HASSAN/DR. WAHEED.** I authorized the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to Dr. Hassan/Dr. Waheed.

Name of person signing below (print):_____

Relationship to Insured:_____

Signature of Insured or Parent/ Guardian: _____

Date: _____

Regardless of my insurance coverage, I am responsible for all bills being paid in a timely manner. I understand my contract is between South Shore Cosmetic Surgeons, LLC and myself. I also understand South Shore Cosmetic Surgeons may not participate in my insurance plan and payment might be directly sent to me, the insured. In this case, I also understand it is my responsibility to forward this payment to South Shore Cosmetic Surgeons, LLC.

Name of person signing below (print):_____

Relationship to Insured:_____

Signature of Insured or Parent/ Guardian: _____

Date: _____