Penn Highlands Healthcare
PENN HIGHLANDS PHYSICIAN NETWORK
1163 Country Club Road
Monongahela PA 15063
(724)258-1000

PATIENT REGISTRATION **TODAY'S DATE** _____

Acct. #

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ **Signature** X _____

I hereby authorize_____ to apply for benefits on my behalf for covered services rendered by him / her, or by his / her order. I request that payment from my insurance company be

made directly to_____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I acknowledge that I received the Notice of Privacy Practices for David R. Sheba, D.O. and Justin J. Sheba, D.O.

Signature X _____

(patient, parent, personal representative)