Assignment of Insurance Benefits

I,________________________________, authorize the release of any medical or other information necessary for Pacific Pedorthic Services Corporation dba, VED Systems, to process and submit my claims to my insurer.

I authorize payments for medical supplies furnished to me by Pacific Pedorthic Services Corporation dba, VED Systems, to be paid directly to Pacific Pedorthic Services Corporation.

I agree that if my insurance company sends me payments, I will send off all the payments received, directly to Pacific Pedorthic Services Corporation dba, VED Systems, without delay.

I understand that my insurance payments for the furnished supplies belong to Pacific Pedorthic Services Corporation dba, VED Systems, and that using the insurance payment for anything other than paying for my supplies is against the law.

Patient Name____

Signature____

Date____/____/_______