



Anodyne Inc.
6024 Blue Circle Drive
Minnetonka, MN 55343

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Fax: 952-546-2657

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby represent that I have Insurance Coverage and do hereby authorize my carrier to pay and assign directly to ANODYNE, INC. all benefits otherwise payable to me for the services rendered.

I hereby authorize ANODYNE, INC. to obtain and release all medical information necessary to process and secure payment of said benefits. If my insurance fails to pay ANODYNE, INC, I agree to pay all unpaid balances and 1.5% interest per month. If litigation is instituted to collect any unpaid balance, I agree to pay all cost of collection including reasonable attorney's fee incurred by Anodyne Inc.

I understand that the equipment and/or supplies provided to me are for my convenience and are provided without qualifications or endorsements of any kind.

Patient Name: _____ Phone: _____

Address: _____

City, State, Zip Code: _____

Social Security # _____ Date of Birth _____

Insurance Carrier: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

ID Policy/Claim #: _____

Group #/Contact: _____

Prescribing Physician: _____

Phone #: _____ DX: _____

Items:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Patient/Authorized Signature: _____ *Date:* _____