

**ERIC J. STELNICKI, M.D., P.A.**

**INSURANCE ASSIGNMENT AND RELEASE**

PRINT PATIENT NAME: \_\_\_\_\_

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE  
INSURANCE WITH \_\_\_\_\_

AND ASSIGN DIRECTLY TO ERIC STELNICKI MD PA ALL INSURANCE  
BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.  
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES  
WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE DR.  
STELNICKI TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE  
PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON  
ALL INSURANCE SUBMISSIONS. I ALSO AUTHORIZE THE USE OF THIS  
SIGNATURE TO FURNISH ALL MEDICAL RECORDS PERTAINING TO  
TREATMENT OF PATIENT.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_