



I O MEDICAL AESTHETICS CLINIC

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**Assignment of Benefits form**

Date: \_\_\_\_\_

I \_\_\_\_\_ authorize Infinite One Medical Aesthetics Clinic (also known as KMH Cardiology and Diagnostic Centres) to receive payment for Massage Therapy treatments for myself and my family.

In the event of a denied claim or deductible, I accept full responsibility for the payments owed to Infinite One Medical Aesthetics Clinic (also known as KMH Cardiology and Diagnostic Centres).

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_