Orna Izakson, ND, RH (AHG)
4921 NE 28th Ave., Portland, OR 97211
503.335.9479v • 503.575.9229f
dro@celilohealth.com

ASSIGNMENT OF BENEFITS

PROVIDER: **Dr. Orna Izakson, ND**
CLINIC: **Celilo Natural Health Center, LLC**
4921 NE 28th Ave.
Portland, OR 97211

PATIENT NAME:_____
(First & Last Name)

DATE OF BIRTH:_____

I request that authorized insurance payments be made on my behalf to **Orna Izakson, ND** at **Celilo Natural Health Center** for any services furnished me by provider or supplier. I authorize the release of any medical information requested about me that is necessary to determine benefits, payable or otherwise, for related services.

_____ _____
Signature **Date Signed**