

Assignment of Benefits

Name of Insured (Print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits be made on my behalf to the organization listed below for any services or equipment provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services or equipment to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payments or products received.

If I fail to make payment for my balance for which I am responsible within 30 days of the patient statement/letter/invoice provided, I authorize the organization to process payment for any unpaid balance on my account to my credit/debit card which may include interest and late payment fees:

_____ Visa MC Debit (circle) Expir. _____ Code: _____.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Organization

The Center for Medical Healing
Dr. Annette DaSilva, DO
161 Madison Avenue, Suite 11E • New York, NY 10016
206 Bergen Ave., Suite 203 • Kearny, NJ 07032
292 Bloomfield Ave • Montclair, NJ

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/ Guardian: _____

Date: _____