Patient Assignment of Benefits Form

PATIENT NAME _____ **DOB** _____

ASSIGNMENT OF BENEFITS

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described.

_____ _____
Signature of patient or legal guardian Date

RELEASE OF INFORMATION

Authorization to release information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

_____ _____
Signature of patient or legal guardian Date

HIPAA PRIVACY POLICY

I acknowledge that Concord OB/GYN has offered me the "Notice of Privacy Practices" in compliance with current HIPAA regulations.

_____ _____
Signature of patient or legal guardian Date

FOR MEDICARE PATIENTS ONLY

LIFETIME ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to the above referenced Medical Practice for services furnished to me. I authorize any holder of medical information about me to release to the Heath Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature of patient or legal guardian Date