

## **ASSIGNMENT OF BENEFITS**

### **Financial Responsibility**

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to the Johnson City Urological Clinic and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify the Johnson City Urological Clinic of any changes in my health care coverage. In some cases exact insurance benefits can not 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 Johnson City Urological Clinic 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 that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

### **Assignment of Benefits**

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to the Johnson City Urological Clinic for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Johnson City Urological Clinic and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by the Johnson City Urological Clinic, and will constitute a continuing authorization, maintained on file with the Johnson City Urological Clinic, which will authorize and allow for direct payment to the Johnson City Urological Clinic of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to my by the Johnson City Urological Clinic.

### **Authorization to Release Information**

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carriers(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to my by the Johnson City Urological Clinic. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carries(s) or other medical entity, if requested. The original authorization will be kept on file by the Johnson City Urological Clinic.

\_\_\_\_\_  
Patient / Insurer (Print Name)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Patient / Insurer (Signature)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Witness (Signature)

\_\_\_\_\_  
Date of Signature