

CROWNVIEW MEDICAL GROUP, INCORPORATED

ASSIGNMENT OF BENEFITS

Patient Name _____ Date _____

PRIMARY INSURANCE

COMPANY _____ PHONE NUMBER _____

SUBSCRIBER ID _____ GROUP NUMBER _____

SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____

INDICATE PERSON TO DISCUSS BILLING ISSUES WITH SUBSCRIBER OTHER _____

I AM I AM NOT COVERED BY A SECONDARY INSURANCE INITIALS _____

SECONDARY INSURANCE

COMPANY _____ PHONE NUMBER _____

SUBSCRIBER ID _____ GROUP NUMBER _____

SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____

The undersigned understand that verification of insurance benefits or any policy(s) is completed as a courtesy by Crownview Medical Group, Inc and Crownview Medical Group, Inc shall be held harmless should the account be rejected by the insurance carrier(s) in whole, or in part. It is the undersigned's responsibility to understand and confirm insurance policy limitations and/or exclusions directly with the insurance carrier. You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however, you are responsible for co-pay amounts and deductibles as set by your benefit plan.

Co-pays are due and payable at the time of each appointment before seeing the Provider. Patients with deductibles will be required to pay a minimum of \$20 per visit as a share of cost. Patients who have Medicare coverage only will be required to pay a minimum of \$35 per visit as a share of cost.

I, THE UNDERSIGNED, hereby irrevocably assign to Crownview Medical Group, Inc all payments for medical services rendered and all major medical benefits. I fully understand that I am financially responsible for any charges not covered by my insurance carrier. If at any time during my treatment I become aware that I am ineligible for insurance coverage, I understand I will be financially responsible for 100% of the outstanding bill. I also undertake to inform Crownview Medical Group, Inc at the earliest convenience of any changes in my personal and/or insurance information.

I AGREE TO THE CONDITIONS AS SET FORTH ABOVE

PATIENT (PRINT) _____ SIGNATURE _____

WITNESS _____ DATE _____

FOR PATIENTS UNDER THE AGE OF 18

RESPONSIBLE PARTY (PRINT) _____ RELATIONSHIP TO PATIENT _____

SIGNATURE _____ DATE _____