What this form does: lays out the terms needed for us to bill your health insurance company or agency for services we provide you.

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance (if any) be made directly to Beargrass Family Medicine, PLLC for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Beargrass Family Medicine, PLLC to disclose any and all written information to the above named insurance company(s) and/or its designated representatives for reimbursement purposes for those services received.

I hereby release Beargrass Family Medicine, PLLC, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action regarding payment for treatment services.
2. I agree to participate and assist Beargrass Family Medicine, PLLC or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Beargrass Family Medicine, PLLC is acting in filing for insurance benefits assigned to Beargrass Family Medicine, PLLCand it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by Beargrass Family Medicine, PLLCfor billing and collection purposes may do billing.
7. Beargrass Family Medicine, PLLC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Beargrass Family Medicine, PLLC shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

Patient name: _____

Patient birth date: _____ Today's date: _____

Patient / legally authorized representative signature: _____

Relationship to patient (if applicable): _____