NEWPORT CARDIAC & THORACIC SURGERY

ASSIGNMENT OF INSURANCE BENEFITS, AUTHORIZATION TO PAY BENEFITS, AND RELEASE OF INFORMATION TO INSURANCE COMPANIES

1) **ASSIGNMENT:** I hereby authorize payment to the Newport Cardiac & Thoracic Surgery, all benefits now due or becoming due under my group policy and I hereby direct my insurance carrier to pay such benefits to said physician. I authorize this practice to act as my agent to help me secure payment from my insurance companies.

2) **MEDICAL PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I hereby certify that the above information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I request payment of any authorized benefits to be made on my behalf. Any holder of medical/other information about me is authorized to release it to the Social Security Administration or its intermediaries or carriers as well as any information needed for this or a released Medicare claim.

3) **RELEASE OF INFORMATION:** I also authorize said assignee to release information to the insurance carrier and other specialists involved in my care related to these services and in reference to the settlement of this claim.

4) **WAIVER:** I agree that should it be determined that I am ineligible for services rendered and/or ineligible due to lack of pre-authorization by my primary care provider, I will be responsible for payment to Newport Cardiac & Thoracic Surgery or its agent for those services deemed ineligible or not covered. I acknowledge that it is my responsibility to ensure pre-authorization has been obtained for services rendered by Newport Cardiac & Thoracic Surgery or its agents.

5) **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED WHETHER OR NOT PAID BY MEDICARE OR SAID INSURANCE.**

6) I UNDERSTAND THAT IF I DO NOT PAY THE OUTSTANDING BALANCE AND MY ACCOUNT IS TURNED TO COLLECTION, THAT A 10% INTEREST CHARGE WILL BE ADDED TO MY UNPAID DEBT.

_____ _____

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

Enclosed in this packet is a copy of Newport Cardiac & Thoracic Surgery's Notice of Privacy Practices. Your signature below signifies that you have received the copy of our Notice of Privacy Practices and have had an opportunity to read it.

I, _____ have received a copy of this office's **Notice of Privacy Practices.**

(print name)

_____ _____

(Signature) *(Date)*

Patient Name _____