Metro Healthcare Partners

ASSIGNMENT OF RIGHTS AND BENEFITS FORM

Please click each statement below to acknowledge.

○ I hereby authorize my insurance company (including private insurance and any other health/medical plan), my employer, my healthcare contractor, agents, assignees, and/or any other organization obligated to cover the cost of my healthcare benefits (collectively, the "Insurance Company") to direct any and all payments for any and all professional and medical services ("Medical Services") that I receive pursuant to my plan benefits directly to Provider(s) and/or Facility(s) providing said Medical Services, or their designated associates or assignee(s) (collectively "Provider"). I hereby authorize the Provider to obtain, including electronically or via email, on my behalf, the insurance plan, insurance and benefits policy booklet, and any and all other policy information from the Insurance Company. I also provide express consent and give full rights to the Provider to initiate and process any appeals on my behalf with my insurance for any reason.

○ I hereby fully assign the Provider any and all payments for Medical Services that are due to me and/or that I received pursuant to my benefits plan from any Insurance Company. I hereby authorize and direct my Insurance Company to issue payment check(s) directly to: Metro Healthcare Partners, 3500 Nostrand Avenue, Brooklyn NY 11229 for Medical Services which are otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered by the Provider. I understand that as a courtesy to me, the Provider will file a claim with my insurance company on my behalf. I understand that my Insurance Company may consider certain diagnoses or services as medically uncovered, medically unnecessary, cosmetic, or excluded. I agree to be financially responsible for, and hereby do agree to pay, in a timely manner, charges for all services received and denied or otherwise not covered by my Insurance Company.

○ If my current policy prohibits direct payment to the Provider, I hereby also instruct and direct any payer to provide payment in my name and mail it to the above address of the Provider for the Medical Services expense benefits that are allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered.

○ Additionally, in the event payment(s) for services are mailed directly to me or to my partner by the Insurance Company, I hereby represent and warrant that I agree to either endorse the check and annotate "Pay to the Order of" : Metro Healthcare Partners, or immediately deposit the check and forward a personal or cashier's check for the full amount to the Provider at the above address.

○ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the Provider, Insurance Company or another medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original will be kept on file by the Provider.

○ I have been informed that the Provider is out- of-network with my Insurance Company and that this will lead to higher fees and increased financial responsibility on my behalf for the Medical Services rendered. I understand this responsibility and request to have my procedure performed at this Facility. I agree that I am responsible for annual deductibles, co-pays and charges not covered by my Insurance Company(s). Physician, Laboratory and Pathology services are billed separately from the Facility. I have been informed that in the event I am able to demonstrate financial hardship, a payment plan may be arranged for payment due for Medical Services which represent patient responsibility.

○ It is my responsibility to notify the Provider of any changes in my healthcare coverage. Exact insurance benefits cannot 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 Provider and/or my Insurance Company if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for Medical Services received.

○ I represent and warrant that I have read and understand the foregoing and agree to abide by and comply with all provisions contained herein.

Print your full name and sign: _____

Signature

X_____