BELLEVILLE LAKE PEDIATRICS
ASSIGNMENT OF INSURANCE BENEFITS, DIRECT-PAYMENT AUTHORIZATION, AND FINANCIAL RESPONSIBILITY

I. PATIENT AND INSURANCE INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____

Guarantor Name (if different): _____

Insurance Company: _____ Member ID Number:_____

By signing below, the patient or authorized signer acknowledges and agrees to the terms set forth herein:

II. LIMITED ASSIGNMENT AND DIRECT-PAYMENT AUTHORIZATION

To the extent permitted by applicable law and the terms of the patient's health plan and any applicable payer agreement, I assign to Belleville Lake Pediatrics the right to receive payment of health insurance and health plan benefits otherwise payable to me or the patient for services furnished to the patient by Belleville Lake Pediatrics, and I authorize and direct my health insurer, health plan, third-party administrator, or other responsible payer to pay those benefits directly to Belleville Lake Pediatrics. If a payer does not honor, or restricts, an assignment of benefits, this assignment applies only to the extent the payer permits.

This assignment applies to services furnished by Belleville Lake Pediatrics on or after the date I sign this form. If any payment for services furnished by Belleville Lake Pediatrics is issued to the patient, subscriber, or guarantor, I agree to promptly forward or endorse that payment to Belleville Lake Pediatrics. I understand that this assignment does not guarantee eligibility for benefits, coverage, or payment by my insurance company or health plan.

III. INFORMATION-USE ACKNOWLEDGMENT

I acknowledge that Belleville Lake Pediatrics may use and disclose the minimum necessary information to verify coverage, submit claims, obtain payment, coordinate benefits, resolve billing issues, and appeal claim denials or underpayments as permitted by applicable law and as described in the practice's Privacy Notice. Nothing in this form overrides any confidentiality rights a minor patient may have under applicable law for certain services, and such information will be handled in accordance with those rights. Any use or disclosure beyond what applicable law permits will require a separate written authorization.

IV. FINANCIAL RESPONSIBILITY

To the extent permitted by applicable law and any payer agreement, I am responsible for: (a) applicable copayments, deductibles, and coinsurance; (b) charges for non-covered services; (c) amounts denied or unpaid by the payer that are the patient's responsibility under the plan or payer agreement; and (d) payments sent to the patient, subscriber, or guarantor and not forwarded to Belleville Lake Pediatrics. Insurance coverage does not guarantee payment of all charges.

V. DURATION AND REVOCATION

This form is effective for services furnished on or after the date signed and remains in effect until revoked in writing. Financial responsibility for services furnished before revocation survives revocation.

VI. REPRESENTATIVE AUTHORITY AND GUARANTY

Name: _____

Relationship to Patient: _____

Authority to Sign: □ Parent □ Legal Guardian □ Conservator □ Other: _____

By signing in a representative capacity, I represent that I have legal authority to sign this form on the patient's behalf, and I agree to provide documentation of that authority to Belleville Lake Pediatrics upon request.

VII. ACKNOWLEDGMENT AND SIGNATURES

By signing below, I acknowledge and agree that:

1. The insurance and personal information I have provided is accurate and complete, and I will promptly notify Belleville Lake Pediatrics of any change in insurance coverage, address, or responsible party.
2. A photocopy, scanned copy, or electronic copy of this form, or an electronic signature on this form, is as valid as the original.
3. I have had an opportunity to ask questions about this form, and I may receive a copy of this form upon request.
4. I authorize Belleville Lake Pediatrics to submit insurance claims on the patient's behalf.

Patient/Legal Representative Signature: _____

Printed Name: _____

Date: ____ / ____ / _____

Capacity (Patient / Parent / Guardian / Other): _____