Assignment of Benefits Form
Henrikson Primary Care
Lynn Henrikson DNP, ACNP, FNP

3371 Knickerbocker Rd, #236
San Angelo, TX 76904

Patient_____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our office. If Henrikson Primary Care has a contractual agreement with my insurance carrier to accept their reimbursement, I understand that I am responsible for any deductible, coinsurance, and copay. I agree to pay my copay at the time of service.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health/medical plans, to issue payment check(s) directly to Henrikson Primary Care for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance or contractual agreement.

Authorization of Release of Information

I hereby authorize Henrikson Primary Care: 1) to release any information (including medical notes) required by my insurance carrier(s) regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; 3) to allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect for one year or until revoked by me in writing.

Acknowledgment

I have requested medical services from the provider at Henrikson Primary Care on behalf of myself and/or my dependents, and I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Patient/Responsible Party Signature

_____ _____
Relationship to Patient Witness

_____ _____
Date Date