Tina Joyce, D.O., LLC
Auburn Rd. Unit 1D
Concord, Ohio 44077
440-375-5520

Assignment of Benefits Form
HIPPA Acknowledgement

Patient Name (print): _____

Name of policy holder _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed above for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier, or any other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases 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 organization and/or my health care insurer 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 products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Signature of Patient _____

Signature Parent/Guardian: _____

PLEASE READ AND CIRCLE YES OR NO FOR THE QUESTIONS BELOW:

Can we leave a message on your answering machine pertaining to your care? _____

Do you have a living will or power of attorney? Yes / No If yes please provide the office a copy.

Do we have your permission to share your medical information with your spouse? _____

Other? _____ (Relationship to Patient)

You do have my permission to treat my minor child? _____

Date_____