PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M \_\_\_\_ F\_\_\_\_

PATIENT PHYSICAL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBERS HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE PRIMARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE READ THE FOLLOWING CAREFULLY** **REGARDING PAYMENT FOR YOUR PURCHASE OF MEDICAL SUPPLIES**

**FINANCIAL POLICY: THE RESPONSIBILITY OF PAYMENT FOR YOUR PURCHASE OF MEDICAL SUPPLIES IS YOURS**

As a courtesy we will file your insurance claims for you and assist you in receiving the insurance benefits for which you are eligible.

Please understand that payment of your bill is necessary.

**WE DO NOT GUARANTEE PAYMENT BY YOUR INSURANCE COMPANY.**

Insurance companies set their own policies limiting your coverage and the amount they will pay. We encourage all insured persons to review and become familiar with the terms and provisions stated in their policy to ensure maximum utilization. Most insurance companies have restrictions, so please be aware. Insurance companies will not guarantee payment. We will provide you with the most accurate **estimate** possible; however, we are not always informed of the limitations on every policy. You are responsible for your balance after your insurance pays regardless of the benefits estimated to you. You are encouraged to contact your insurance company or review your benefits booklet to help you determine that you are receiving the maximum benefit to which you are entitled. You may be asked to pay your **estimated** portion at the time you pick up your medical supply. After payment is received from your insurance, the remaining balance is your responsibility. A service charge of 18% per year will be added to all balances unpaid after 90 days from your insurance determination of liability. Any claims left unpaid after 180 days will be turned over to a collection agency. Any overpayment will be refunded to you.

**ASSIGNMENT OF BENEFITS AGREEMENT**

I give Mill Plain Medical authorization to bill my insurance company directly and receive payment for my DMEPOS supplies. I understand that I am responsible for all outstanding unpaid bills that my insurance does not reimburse Mill Plain Medical. I have been offered a copy of the Medicare Supplier Standards.

**BY SIGNING I AM ATTESTING THAT ALL THE INFORMATION ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACCEPT RESPONSIBILITY OF ANY PAYMENT DUE FOR THE MEDICAL SUPPLIES**

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF NOT THE PATIENT; PRINT NAME, RELATIONSHIP AND PHONE NUMBER:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_