ARTHEON MEDICAL

ASSIGNMENT OF BENEFITS

AOB • PATIENT AUTHORIZATION & CONSENT FORM

Notifier: Artheon Medical · Contact: (813) 367-1110 · Patient Name: _____

We perform billing of Medicare, Medicaid and other insurances as a service. I certify that the information given to me in applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about me to release it to the Centers for Medicare/TPL and Medicaid Services or its agents any information needed for this or a related Medicare/TPL claim. I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for services to be paid to Provider or authorize Provider to submit a claim to Medicare/TPL for payment to me. Assignment of Medicare/TPL claims does not mean that Medicare/TPL pays your entire bill. Patient's responsibility on assigned Medicare/TPL claims includes payment of: Annual Medicare/TPL deductible, 20% co-insurance or TPL copay or deductible on approved services, Non-covered services or Services rendered under an ABN, covered, but not paid by Medicare/TPL. For those with Medicare and Medicaid, Medicaid may pay for all approved and covered items that Medicare does not pay for. You will never be billed for Medicare/Medicaid approved services that we provide to you unless you have a share of cost responsibility. This notice describes how health information may be used and disclosed and how a patient can get access to their health information. I have been advised by Provider to read this document and to forward any questions to their Compliance Officer at the above number. I consent to receiving services from this provider and to receiving the following documentation: 30 Supplier Standards, Care & Use paperwork for products I received, Warranty Return policy, Capped Rental P/O Letter (if applicable) and notification of how to voice a complaint. I authorize any holder of medical records and/or any information necessary to determine benefits and payment on my behalf, to release it to this provider for any request made by them or my insurance carrier. I permit a copy of this authorization to be used in place of the original. I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA HI-TECH PRIVACY NOTICE AND AUTHORIZATION identified above disclose full and complete protected medical information. This protected health information is disclosed for all healthcare related purposes. I consent to receiving a copy of the HIPAA HI-TECH PRIVACY NOTICE AND AUTHORIZATION, which is given in compliance with the federal consent requirements. The informed consent requirements in this policy are not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed for informed consent to be legally effective. Nothing in this policy is intended to limit the authority of a physician to provide emergency medical care, to he extent the physician is permitted to do so under applicable federal, state, or local law. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until revoked by me. By signing above, I acknowledge receipt and acceptance of the items listed above. I consent to receiving my medical supplies from this supplier. If I have any questions or concerns, I will contact them to discuss my options.

By signing below, I confirm that I have received and read this Assignment of Benefits (AOB) and hereby assign my insurance benefits to Artheon Medical for the services provided. If signing on behalf of the patient, please state your relationship to the patient and sign below:

PATIENT / REPRESENTATIVE SIGNATURE

Printed Name: _____

Signature: _____ **Date:** _____

Relationship to Patient (if applicable):

☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Parent** ☐ **Power of Attorney**