229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385
www.endocrinewellness.com

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003
www.endocrinewellness.com

Name of patient (print): ____

I hereby acknowledge and confirm that, by signing this Assignment of Benefits, I have requested medical treatment, diagnostics and/or other medical or healthcare services (the "Medical Services") from Endocrinology Consultants P.C. ("Endocrinology Consultants") on behalf of myself and/or my dependents. Furthermore, I acknowledge and agree that I am fully financially responsible for any and all fees and payments associated with any and all Medical Services rendered to myself and/or to my dependents (the "Fees"), including without limitation, any co-pays and deductibles. The Fees shall be charged, and payment in respect of such Fees are due, on the date the Medical Services that are the subject of such Fees are rendered. **In the event that the insurance company sends a check to me for any services rendered, I will forward the payment to Endocrinology Consultants, P.C.**

Additionally, I acknowledge and agree to each of the following:

1. I hereby assign to Endocrinology Consultants any and all payments and benefits (each such payment or benefit, a "Benefit") of any kind whatsoever to which I, or any of my dependents, are entitled to (or have actually received), whether it be from a private insurance provider, government source (including, without limitation, Medicaid and/or Medicare) or any other third-party payer (any of the above payment and benefit sources, an "Insurance Provider"), in connection with the Medical Services.
2. Any Fees that are due and payable for over [sixty (60)] days shall accrue interest at the rate established by applicable New Jersey State law for such overdue payment. I understand that if a balance is unpaid, my account may be referred to a collection agency and/or a legal office.
3. I hereby authorize and direct any and all Benefits that are due, pending or that I am in any way entitled to, from any Insurance Provider in connection with the Medical Services, to be issued and paid directly to Endocrinology Consultants. This authorization fully applies to any and all Fees regardless of whether Endocrinology Consultants is in-network or out-of-network with the Insurance Provider providing such Benefit(s).
4. I understand and agree that, regardless of any Benefit to which I, or any of my dependents, are entitled to or actually receive, I am fully responsible for any Fees due to Endocrinology Consultants in connection with the Medical Services, that have not been actually received by Endocrinology Consultants for any reason, including without limitation, due to a non-payment or claim denial by any Insurance Provider.
5. I agree to assist Endocrinology Consultants in their efforts to obtain payment for any Medical Services from any Insurance Provider. However, I fully understand that it is ultimately my responsibility to pay any and all Fees and to obtain any and all required authorizations and/or precertification(s) for any and all Medical Services.
6. I understand that no guarantees have been made by Endocrinology Consultants or any other party in respect of any Medical Services or whether the Fees associated with such Medical Services will be paid for by any Insurance Provider.
7. I hereby authorize Endocrinology Consultants to:

i. release any information, in connection with the Medical Services, necessary or beneficial to receive any Fee, to any Insurance Provider or other relevant third-party;

ii. process insurance claims in connection with the Medical Services; and

iii. use a photocopy of my signature to process any and all insurance claims.

8. I acknowledge and confirm that I have received a copy of Endocrinology Consultants' 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.

A photocopy of this assignment is to be considered as valid as the original. This Assignment of Benefits shall remain in full force and effect until there are no Fees owed to Endocrinology Consultants in connection with the Medical Services.

Name of person signing below (print): ____________________Relationship to insured: _____________________
Signature of Insured or
Parent/Guardian:____Date:________________