DELAWARE VALLEY OBGYN & INFERTILITY GROUP

PATIENT NAME _____ **DOB** _____

RACE _____ **SPOUSE** _____ **SPOUSE#** _____

PHARMACY _____ **PHARMACY#** _____

ASSIGMENT OF BENEFITS AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Delaware Valley OBGYN & Infertility Group, PC to apply for benefits on my behalf for covered services. I request payment from my Insurance company (or Medicare) be made payable directly to them.

I understand that I am enrolled in a managed care insurance program; It is my responsibility to obtain and bring a referral from my primary care physician for all medical services. Any services rendered without this referral will be subjected to payment at time of service.

I understand that I am responsible for all charges, regardless of Insurance coverage. In addition, I am aware that unless otherwise stated, all laboratory charges will be billed separately by the laboratory. Approximate fees are available from the business office upon request.

If it becomes necessary for me to receive a copy of my medical records, I understand that a fee may be incurred for this service.

LATE PAYMENTS RECEIVED 30 DAYS AFTER BILLING DATB ARE SUBJECT TO A 5% PENALTY CHARGE.

IF I FAIL TO INFORM THE BUSINESS OFFICE OF ANY CHANGES IN MY INSURANCE, I AM PERSONALLY RESPONSIBLE FOR ALL MEDICAL BILLS FOR SERVICES RENDERED TO ME.

If you are referred for any services outside of this office such as Mammogram, Ultrasound, Obstetrical Services, etc., it is your responsibility to obtain your referral and/or your scripts. If you go to any hospital or other office facility without these necessary documents, they will expect payment or they will re-schedule your procedure.

SIGNATURE _____ **DATE** _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: HOME# _____

CELL# _____ **EMAIL:** _____

I hereby authorize permission for you to discuss my care with the following person(s):

NAME _____ **RELATION** _____ **PHONE#** _____

NAME _____ **RELATION** _____ **PHONE#** _____

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (HIPAA) govern the terms of this authorization. I also understand that I may revoke this authorization at any time. Each dated signature valid for one year.

NAME _____ **DATE** _____