Assignment of Benefits Form Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that services rendered to me by A Step Ahead are my financial responsibility and that the provider will bill my insurance company, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a courtesy. I authorize my insurance company to pay my benefits directly to A Step Ahead and I understand that I may or may not be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional charges over and above this insurance payment if needed.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I authorize the provider to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me, needed to substantiate payment for medical services as well as information required for precertification, authorization or referral to any medical provider.

I also understand that should my insurance company send payment to me, I will forward the payment to A Step Ahead within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft or payment subject to this agreement, I will immediately deliver said check, draft or payment to the provider. Any violations of this agreement will, at provider selection, terminate patient charge privileges with provider and bring any balance owed by patient to A Step Ahead immediately due and payable.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Policy Holder/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder/Guardian Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_