CROWNVIEW MEDICAL GROUP, INCORPORATED

ASSIGNMENT OF BENEFITS

Patient Name____ Date______________

PRIMARY INSURANCE

COMPANY___________________________________ PHONE NUMBER____________________

SUBSCRIBER ID____________________________ GROUP NUMBER__________________________

SUBCRIBER_______________________________ RELATIONSHIP TO PATIENT__________________

INDICATE PERSON TO DISCUSS BILLING ISSUES WITH ☐ SUBSCRIBER ☐ OTHER______________

I AM ☐ I AM NOT ☐ COVERED BY A SECONDARY INSURANCE INITIALS _________

SECONDARY INSURANCE

COMPANY___________________________________ PHONE NUMBER____________________

SUBSCRIBER ID____________________________ GROUP NUMBER__________________________

SUBCRIBER_______________________________ RELATIONSHIP TO PATIENT__________________

The undersigned understand that verification of insurance benefits or any policy(s) is completed as a courtesy by Crownview Medical Group, Inc and Crownview Medical Group, Inc shall be held harmless should the account be rejected by the insurance carrier(s) in whole, or in part. It is the undersigned's responsibility to understand and confirm insurance policy limitations and/or exclusions directly with the insurance carrier. You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however, you are responsible for co-pay amounts and deductibles as set by your benefit plan.

Co-pays are due and payable at the time of each appointment before seeing the Provider. Patients with PPO insurances where deductibles apply, will be required to pay a minimum of $20 per visit as a share of cost. Tricare dependents or sponsors which are no longer active duty, will have a $12 co-pay for the initial visit then $25 for follow-ups. Patients who have Medicare coverage only will be required to pay a minimum or $35 per visit as a share of cost.

I, THE UNDERSIGNED, hereby irrevocably assign to Crownview Medical Group, Inc all payments for medical services rendered and all major medical benefits. I fully understand that I am financially responsible for any charges not covered by my insurance carrier. If at any time during my treatment I become aware that I am ineligible for insurance coverage, I understand I will be financially responsible for 100% of the outstanding bill. I also undertake to inform Crownview Medical Group, Inc at the earliest convenience of any changes in my personal and/or insurance information.

I AGREE TO THE CONDITIONS AS SET FORTH ABOVE

PATIENT (PRINT) ____________________________________ SIGNATURE_______________________________

WITNESS____ DATE____________________________________

FOR PATIENTS UNDER THE AGE OF 18

RESPONSIBLE PARTY (PRINT) ____________________________ RELATIONSHIP TO PATIENT____________________

SIGNATURE____ DATE______________________