

David V. Nenna, M.D., P.A.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/APPEALS

I have been provided with and have read the "Financial Policy of David V. Nenna, M.D., P.A." and have had my questions answered regarding it.

- Assignment of Benefits:** I hereby authorize direct payment to David V. Nenna, M.D., P.A. ("My Doctor") of the medical insurance benefits otherwise payable to me, but not to exceed the regular charges for this period of medical care. I understand I am financially responsible to the physicians for charges not covered by this authorization. I understand that if these services require precertification/authorization from my managed care plan and I fail to obtain the necessary precertification/authorization, that I am financially responsible for these services.
- Appeals:** In the event that Medicare, Medicaid, my health insurance plan, or any other person or entity responsible for payment for services provided to me by My Doctor fails or refuses to pay for these services, or underpays for these services, I hereby authorize My Doctor to pursue on my behalf all available company, administrative, and legal appeals and rights that I may have to contest such failure, refusal, or underpayment. This also includes authorization for My Doctor to contact My Employer/Employer Benefits Manager to verify benefits on my behalf.
- Joint Checks:** In the event any governmental agency or any insurance carrier issues a check payable to me and to My Doctor, I hereby agree to endorse the check and turn it over to My Doctor. The amount of the check is to be applied to amounts owed by me for health care services that I have received from My Doctor.
- Release of Information:** I hereby authorize My Doctor to release to governmental agencies, insurance carriers, employers, or others who are financially liable for my medical care, and to agencies handling appeals of payor payments decisions, and to collections agencies and others assisting My Doctor in obtaining payment for services, any and all information needed to effect payment for such medical care or as otherwise requested by the payor. This authorization applies to all information, including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV-related information, if applicable. I understand that I may revoke this authorization at any time, but that if I do so, my insurer or other payor may not pay for my medical care, and I may be personally responsible for payment. This authorization will expire when My Doctor has received payment in full for my medical care and payor liability has been finalized.
- Notice of Privacy Practices:** By placing my initials at the end of this paragraph, I hereby acknowledge receipt of David V. Nenna, M.D., P.A.'s Notice of Privacy Practices: _____.

Patient Signature (Patient or Authorized Representative)

Date

Witness