Lawrence Medical Associates, P.C.

Assignment of Benefits

Last Name:_____ First Name: _____

MRN: _____ Dr._____

I understand that I am financially responsible to ***Lawrence Medical Associates*** for any charge not covered by my health care benefits or is applied to my deductible. It is my responsibility to notify the organization at the time of registration of any changes in my health care coverage.

In some cases the exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Lawrence Medical Associates and/or my health care insurer if submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

In certain circumstances, an insurance carrier may send a check for services provided by the above named physician directly to the patient. In such cases, the patient agrees to endorse and send such check to ***Lawrence Medical Associates***. If the patient deposits such check into a personal account, the patient agrees to send ***Lawrence Medical Associates*** a check for the equivalent amount.

If the patient receives from an insurance company an Explanation of Benefits (EOB), the patient agrees to send a copy of the EOB, to us directly.

_____ _____

Print Insured Name Date

_____ _____

Signature of Insured Date

_____ _____

Employee Signature (Witness) Date