HUDSON HEADWATERS HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

ASSIGNMENT OF BENEFITS

I, _____, _____ understand that my health information may be used
(Patient's name) *(date of birth)*
or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to the Network for medical services rendered to myself and/or my dependents.

I request that payment of authorized medical benefits is made on my behalf directly to Hudson Headwaters Health Network (HHHN). I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, 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 HHHN and/or my health care insurer if the 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 products and services received.

I understand that refusal to sign this form prohibits Hudson Headwaters Health Network from billing my health care insurer and that I will be personally responsible for any charges associated with any service(s) rendered.

This assignment will remain in effect until revoked by me in writing and is not invalidated by any changes in my health care insurance plan or health care insurer. A photocopy of this assignment is to be considered as valid as an original.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date