# DACOSTA MEDICAL GROUP
# ASSIGNMENT OF BENEFITS

Patient
Name_____
Last First Middle

I request that payment of authorized insurance benefits be made on my behalf to DACOSTA MEDICAL GROUP services furnished to me. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE INSURANCE POLICY(S)** mentioned herein and attached hereto. I authorize any holder of my medical information and records to release to the health care financing administration and its agents, or any insurance company any information needed to determine these benefits or the benefits payable for the related services.

***** I HEREBY INSTRUCT AND DIRECT YOU TO MAKE THE CHECK OUT TO THE PROVIDER LISTED BELOW AND MAIL IT AS FOLLOWS:**

***DaCosta Medical Group***
***59 Main Street, Suite 1***
***West Orange, NJ 07052***

If applicable, I hereby authorize DACOSTA MEDICAL GROUP, to commence arbitration and/or litigation proceedings against the appropriate insurance carrier and/or initiate a complaint to the Insurance Commissioner for any reason on my behalf in order for said providers to obtain payment for services furnished me at DACOSTA MEDICAL GROUP.

I understand and agree that this assignment does not discharge my responsibility in the event that my insurance company does not make payment and that I am financially responsible for the fees for services rendered. I have seen, been directed to and provided the opportunity to review the list of patient rights and the notice of privacy policies. A Photocopy of this Assignment shall be considered as effective and valid as the original.

I further agree that in the event my insurance company sends payment to me, instead of DACOSTA MEDICAL GROUP, I will forward said payment immediately to the aforesaid Doctors respectively. If I fail to do so, either Doctor shall be entitled to institute collection proceedings to obtain said sums from me. I agree that in this event I will be responsible for all costs of collecting or obtaining such funds or any such further funds I owe for services rendered.

PATIENT SIGNATURE_____ DATE_____

GUARDIAN
SIGNATURE_____ DATE_____
(If patient is a minor)

Print name_____ Relationship to patient_____

WITNESS
SIGNATURE_____ DATE_____

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