

Reds Ankle & Foot Associates, LLC

Assignment of Benefits, Release Form & Financial Policy

Patient Name: _____ Date of Birth: _____

Primary Insurance: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber Employer: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber Employer: _____

I hereby instruct and direct the mentioned insurance companies to pay directly to:

Reds Ankle & Foot Associates
444 Market Street, Saddle Brook, NJ 07663
425 39th Street Union City, NJ 07087

This is a direct assignment of my rights and benefits under this policy

I understand and agree that, regardless of my insurance status, **I am ultimately responsible for the balance of my account** for any professional services rendered. I am responsible for any co-pays, co-insurances, deductibles, uncovered services and/or denial of benefits. I will contact my insurance company immediately to straighten any matters that are hindering payment. I will pay my balance in full within 45 days unless other arrangements have been made with the billing department.

I also authorize the release of any information pertinent to my medical treatment to any doctor, insurance company, adjustor or attorney involved.

Is today's visit related to an auto accident, Worker's Compensation or school incident?

Yes _____ No _____

Signature _____ Date: _____

Relationship (if not self): _____