Mike M. Pappas, D.O.
Suffolk Rehabilitation Medicine, PLLC
220 Fort Salonga Rd.
Northport, NY 11768

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print)_____

Social Security#_____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed above (Suffolk Rehabilitation) for any services or equipment provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits payable to the related services or equipment to the organization, the Healthcare Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Healthcare Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by healthcare benefits. It is my responsibility to notify the organization of any changes in my healthcare 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 the organization 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 received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):

_____

Relationship to Insured:

_____

Signature of Insured or Parent/Guardian:

_____