ASSIGNMENT OF BENEFITS

Please Note: All information is confidential and will become part of your medical record.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize and direct PRINCETON WOUND CARE CENTER, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to PRINCETON WOUND CARE CENTER sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

For Medicare patients: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment.

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Signature of Patient or Authorized Guardian Date

Name: ______________________________________ Account Number: ____________________________