SOUTHERN WESTCHESTER ORTHOPEDICS & SPORTS MEDICINE ASSOC., P.C.
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DAVID E. LENT, M.D., F. A. A .O. S.
ERIC M. SPENCER M.D.

ASSIGNMENT OF BENEFITS FORM

Name of insured (print): _____

Insured ID #: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Southern Westchester Orthopedics & Sports Medicine Assoc., P.C. for any equipment or services provided to me by Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Southern Westchester Orthopedics & Sports Medicine Assoc., P.C., my insurance carrier, or other medical entity.

I understand that I am financially responsible to Southern Westchester Orthopedics & Sports Medicine Assoc., P.C. 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. I am responsible for the entire bill or balance of the bill as determined by Southern Westchester Orthopedics & Sports Medicine Assoc., P.C. 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.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

For questions regarding this form or for general questions, please call us at (914) 476-4343.