Assignment of Medical Benefits

I, _____, understand that I am seeing Atlantic Spine Specialists and as a courtesy the office will be billing my insurance company. However, I do understand that should my insurance company send the payment to me, I will forward the payment within 48 hours to Atlantic Spine Specialists. I also understand that should I not send the payment to the office and the office has to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their moneys. I also understand that the office may have to report said payment to the Internal Revenue Service as income.

I authorize my insurance company to pay my benefits directly to Atlantic Spine Specialists and I understand that I will be fully responsible for any outstanding balance on my account.

Signature: _____ Date: _____

Receipt of Privacy Act

I, _____, acknowledge that I have received a copy of the PHI from Atlantic Spine Specialists. I realize that if at any time I have any questions regarding PHI I may contact the office.

Signature: _____ Date:_____