Print

Notice of Assignment of Benefits to a Provider

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

Insurance Authorization and Assignment of Benefits

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice, authorizing this transfer of payment from the insured to the healthcare provider, Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice.

I, _____ ,
[Print the full name of the undersigned]
herby absolutely authorize Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payments be sent directly to Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice. I understand that it is the policy of Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice to only bill my insurance company(ies) if they participate in that company's network, and if they do not, it will be my responsibility to bill my insurance company(ies) for reimbursement of my expenses.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice with the up-to-date and correct insurance identification card(s) as well as supplied Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied within may result in denial of payment(s) to Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice and resubmitted claims with corrected updated information that are still denied due to the fact that the corrected information was not supplied in a timely fashion to Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice and I understand that it will be my responsibility to pay Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees (25% is deemed reasonable), court costs, and other expenses incurred as a result of said collection or court date, all actions having a venue of Howard County, MD, other venues notwithstanding. Further, I understand that there is a $30.00 fee for returned checks and a late payment charge not to exceed 1.5% applies to any balance carried forward to next month's bill.

I understand that Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice will report to commercial credit bureaus only when an account becomes delinquent. Accounts having no payments within 30 days of the initial debt notice are considered delinquent for payment purposes. Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice will report a delinquent account to the credit bureau if they do not receive a payment within 62 days of the date of the initial debt notification letter. All delinquent accounts are reported as a "collection account" on the consumer credit report. The debt will remain as a collection account while on the credit bureau report; however, any subsequent payment activity is reported to the credit bureaus on a monthly basis.

I certify that the information I have reported with regard to my insurance coverage is correct and I herby authorize Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

X _____

Signed (Patient or Other Person Authorized to Act for Patient): Date Time

_____ Witnessed By:

Print Name:

_____ _____

Relationship to patient Signed (Witness) Date Time

_____ _____

Address Print Name:

_____

Address

Print

Reset Form

Acknowledgment of Receipt of Notice of Privacy Practices

Earl V. Wilkinson, M.D., Earl V. Wilkinson, MD, LLC medical practice has provided you a copy of its Notice of Privacy Practices. The HIPAA Notice of Privacy Practices explains your privacy rights and how we may use and disclose your protected health information.

If you have any questions about the information described in the HIPAA Notice of Privacy Practices, please contact the Privacy Officer at 410-964-5226.

My signature below indicates that I have been provided with a copy of HIPAA Notice of Privacy Practices.

X _____

Signed (Patient or Other Person Authorized to Act for Patient): Date Time

_____ _____

Print Name: Date of Birth

_____ _____

Relationship to patient Signed (Witness) Date Time

_____ _____

Address Print Name:

_____

Address