Pompano Beach Internal Medicine

Eugenio Menendez, D.O., P.A.

d/b/a **Pompano Beach Internal Medicine**

Office of **Eugenio L. Menendez, D.O., F.A.C.P.**

Board Certified -- Internal Medicine

www.PompanoBeachInternalMedicine.com

ASSIGNMENT OF BENEFITS
(LIFETIME AUTHORIZATION)

I request that payment of authorized Medicare and/or insurance benefits be made to me or on my behalf for any services furnished me by Eugenio Menendez D.O., P.A. dba Pompano Beach Internal Medicine. I further authorize the release of any information acquired in the course of my examination or treatment.

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 below for any equipment or services provided to me by that organization.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 the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original authorization will be kept on file by our practice in the patient's medical record attachments.

I understand that I am financially responsible to the organization 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. 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 (HIPAA) to ensure that I have been made aware of my privacy rights.

PATIENT/INSURED- FULL NAME (FIRST, MIDDLE INITIAL, LAST):
_____(print) Please sign here: _____

Patient's Guardian/Caretaker (if any) – Full name (First, Middle Initial), Last):

_____(print) Plase sign here if applicable: _____

Relationship to Patient/Insured:_____contact cell telephone: _____
contact email address: _____

Medical Practice
1600 E Atlantic Blvd. First floor
Pompano Beach, FL 33060-6768
www.PompanoBeachInternalMedicine.com

(954) 942 2247 * Fax (954) 942 2265
Marketing/New Patients (754) 205 5891

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Signature of Insured or Parent/Guardian: _____

Date: _____

_____ _____

SIGNATURE DATE

_____

WITNESS

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