Hygieia Clinic Michigan, PC
28807 Eight Mile Road, Suite 102
Livonia, MI 48152
(734) 743-2838

Assignment of Benefits and Patient Financial Responsibility to Hygieia, P.C.

To provide timely and accurate payment to Hygieia, P.C. (Provider) for any medical care or services furnished to the Patient designated below, the Patient states the following:

Patient Financial Responsibility

Patient is responsible for all charges and agrees to pay for care and services provided to the Patient by Provider which are not covered by Patient's Health Insurance or for which Patient is responsible for payment under Patient's Health Insurance.

Assignment of Benefits

Patient certifies that the insurance or group health plan information that Patient has provided to the Provider is accurate, complete and current.

Patient irrevocably assigns to the Provider, all of Patient's rights and benefits, including the right to payment, and any other interests that Patient has in any individual medical or health insurance, group medical or health care plan in which Patient participates, Medicare or Medicaid (Health Insurance) for care or services provided by the Provider.

Patient authorizes the Provider to submit any claims and pursue any appeal of a denial of payment or adverse benefit determination on the Patient's behalf related to services and care provided by Provider.

If Patient's Health Insurance will not direct payment to the Provider, Patient agrees to forward to the Provider all health insurance payments which Patient receives for the care or services rendered by the Provider.

Release of Information

Patient authorizes the Provider to release to Patient's Health Insurance provider such information as is needed to determine these benefits or benefits payable for related services.

Patient Acknowledgement

This form with assignment of benefits applies and extends to current and future care and services provided by Provider. The Patient certifies that they have read and understand the above statements and that Patient agrees with each statement above.

Signature of Patient, Guardian, or Authorized Person

Date

Print Name