



Philadelphia Women's Center

For Patients Planning to Use Insurance

Assignment of Benefits (Consent to Bill Insurance)

I hereby authorize my insurance company to pay the Philadelphia Women's Center (PWC) for any professional or medical expense benefits I am eligible for under my insurance policy, as payment toward the total charges for the professional services rendered. I hereby agree that PWC may receive such payment, and instruct and direct the aforementioned insurance company to pay by check made out and mailed to:

**Philadelphia Women's Center, Inc.
601 Chapel Avenue East
Cherry Hill, NJ 08034**

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to Philadelphia Women's Center at the address above.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this Insurance payment. **I am aware that I am financially responsible for all charges not covered by my insurance.** While every attempt to maintain my confidentiality will be taken, if charges are not paid within thirty (30) days, I understand that my protected health information (PHI) may be disclosed to a collection agency in order to obtain payment for the services I was provided. Although the staff of PWC will assist in the verification of insurance benefits, I understand that there is no guarantee of payment, and that I am ultimately responsible for all charges related to my care that are not covered by my policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

I expressly authorize PWC to furnish the insurance company with any PHI concerning my medical and/or surgical treatment as related to services rendered by Philadelphia Women's Center Physicians and employees. I further authorize Philadelphia Women's Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Should I choose to have surgery with anesthesia (sedation), or if sedation is required, I authorize and assign the health insurance benefits to which I am entitled to Philadelphia Anesthesia Group (PAG) for their services. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize PAG, to whom I assign benefits, to release any information about me that is necessary to process their claim. In the event that this account must be assigned to collections, I agree to pay all costs, including reasonable attorney fees.

Coordination of Benefits

I understand that if I am covered by more than one insurance policy, the primary insurance is to be billed first. I agree to provide Philadelphia Women's Center with information about all insurance plans that provide coverage to me.

I certify that I do not have any other health insurance coverage, or that I have provided information on any other policies that cover me. I understand that I am responsible for any remaining charges that are not paid by my insurance company. **If for any reason the claim is rejected or payment is denied, I will be responsible for charges incurred.**

Patient Signature Date

Parent Signature, if applicable Date

Staff Witness Signature Date