Assignment of Benefits, Release of Information, Payment Agreement, and HIPAA Notice of Privacy

Most patients will have some financial responsibility for the services they receive from Boston Spine & Scoliosis, depending on their insurance coverage. This document highlights that the responsibility you may have. Related to the services you will receive, it also authorizes Boston Spine & Scoliosis and/or its associated physician groups to disclose information from your medical records as it is deemed reasonably necessary, in a HIPAA compliant manner, for claims processing and payment.

If you are a member of a Managed Care Plan, then it is your responsibility to ensure that you adhere to your plan's requirements in your member agreement to obtain a valid referral or authorization from your Primary Care Provider (PCP) or insurance carrier. If you are seeing a PCP that is not listed as your PCP with your health plan, your health plan may deny coverage for that visit and you will be financially responsible, with the exception of MassHealth Managed Care members.

If you do not have active insurance coverage, or you are receiving services that are not covered by your health insurance benefit plan, you are considered a self-pay patient and responsible for the balances related to the services you receive.

MY SIGNATURE BELOW CONSTITUES MY ACKNOWLEDGEMENT.

1. I have read and understand the information provided in this form above.
2. I authorize the HIPAA compliant release of my medical records, including all HIV/AIDS related testing and treatment information to my health insurer for claim processing and payment purposes.
3. I authorize that my insurance benefits are to be paid directly to Boston Spine & Scoliosis and/or its associated physician groups. I acknowledge that I am responsible for all balances that are deemed by my health insurance plan to be my responsibility including deductibles, co-insurance, co-payments, and other services not covered by my plan. If I do not have active insurance, I am responsible for the balances related to services I receive.

I understand that if I provide a phone number, I authorize Boston Spine & Scoliosis and/or its associated physician groups may contact me at this number for matters related to my care, including treatment, payment of my bill, or healthcare operations. It is my responsibility to notify Boston Spine & Scoliosis and/or its associated physician groups if my phone number changes.

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Boston Spine & Scoliosis will be filing my insurance on my behalf.

Boston Spine & Scoliosis is an office integrated with MassGeneral Brigham and Milford Regional Medical Center. These hospitals and entities, as well as the doctors, nurses, therapists, and other providers of healthcare who work in these organizations are called "providers". These providers may share patient health information for treatment, billing, and healthcare operations.

Federal law requires that all patients be given a copy of a Privacy Notice. The Privacy Notice describes in detail how patient health is used and shared with others.

You may obtain a current copy of the Privacy Notice by contacting our office.

All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by email or facsimile mail.

Patient/Guarantor Signature _____

Printed Name _____

Date Received _____