



AUTHORIZATION FOR CLAIMS PAYMENT AND REVIEWS

- 1. Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Domestic Abuse Project (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Domestic Abuse Project (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.
- 2. Unauthorized, Non-Covered, or Out of Plan Services** – I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission, or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Domestic Abuse Project for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.
- 3. For Medicare Recipients Only** – I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.
- 4. Residents, Interns or Medical Students** – I understand residents, interns, medical students, and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Domestic Abuse Project education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by **Domestic Abuse Project**. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to **Domestic Abuse Project**, unless specifically rescinded in writing by me.*

Patient Signature

Date

Relationship to Patient