# Assignment of Benefits

Patient:_____ Today's Date: _____

Home Address:_____

DOB:_____ SSN:_____

Primary Ins:_____ Insured Name:_____

**Responsible Party:** _____ Phone: (____)_____

**Notice of Assignment of Benefits to a Provider:** An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital or another medical provider.

**Insurance Authorization and Assignments of Rights and Benefits:** Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to **CANYON RIDGE SURGERY CENTER, LLC** authorizing this transfer of payment from the insured to the healthcare provider **CANYON RIDGE SURGERY CENTER, LLC**.

**I** _____ hereby absolutely authorize **CANYON RIDGE SURGERY CENTER, LLC** to apply for benefits on my behalf for services rendered to me or my dependent and request that payment be made by my insurance company and that payments be sent directly to **CANYON RIDGE SURGERY CENTER, LLC**. In consideration of medical services to be provided, I understand that I am ultimately and fully responsible for payment for those services in accordance with the rates and terms now in effect at **CANYON RIDGE SURGERY CENTER, LLC** to include amounts not paid by my health insurance policy or coverage and to the extent that I am legally responsible. In exchange for not being billed at this time for the services, I hereby irrevocably assign **CANYON RIDGE SURGERY CENTER, LLC** any and all rights and benefits (including the right to file suit), and all interests (including the right to collect the unpaid insurance benefits, penalties, attorney's fees, court costs, and all other recoverable damages of any nature from the medical insurance company that provided coverage on the date listed herein) for services rendered under any insurance policy or prepaid healthcare plan. This assignment includes the right to bring to litigation the insured's medical insurance company in the insured's name and assert all claims that the insured will have against the insurance company resulting from, or in any way pertaining to, the medical coverage that the insured is alleged to have had with his/her insurance company regarding aforementioned medical procedures to be performed. Further, I agree to cooperate with **CANYON RIDGE SURGERY CENTER, LLC** in providing documents and testimony concerning the rights assigned herein. I acknowledge that any balance not covered or paid by such insurance policy, or plan not covered by Medicare or Workers Compensation, is my legal responsibility. I authorize the release of information to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing Medicare/Medicaid claims. I request that payment and authorized benefits be made on my behalf, and I assign benefits payable for services be rendered to **CANYON RIDGE SURGERY CENTER, LLC**. My health insurance company is to pay **CANYON RIDGE SURGERY CENTER, LLC** directly for the services provided to me and without any further verification or authorization from me. **Member Initials:_____**

**Authorization to Release Information:** I authorize to have complete access to all my medical information and records to include my hospital medical information and records. I authorize **CANYON RIDGE SURGERY CENTER, LLC** to furnish requested information from my medical and other records to any insurance or third-party payer, or to any other persons or entities financially responsible for the patients care or treatment, including representatives of local, state, or federal agencies in accordance with applicable law, for the purpose of obtaining payment on the account. Additionally, I authorize **CANYON RIDGE SURGERY CENTER, LLC** to release information or copies of these records to any referring physician or healthcare facility as necessary or as may be required by state or federal law or pursuant to a lawsuit. **Member Initials:_____**

**Acknowledgment of Receipt of Notice of Privacy Practices CANYON RIDGE SURGERY CENTER, LLC** has provided you with a copy of its Notice of Privacy Practices. The HIPAA Notice of Privacy Practices explains your privacy rights and how we may use and disclose your protected health information. **Member Initials:_____**

**Acknowledgment of Duty to Pay Provider:** *I _____ acknowledge that I remain responsible for payment to Provider for all services rendered. Although I have assigned my benefits for medical services from this Provider to said Provider and have (above in this document) instructed my health insurance company to pay Provider directly for the services provided to me and without any further verification or authorization from me, if my health insurance company does not accept the assignment of benefits as valid and does not pay Provider directly, I remain ultimately responsible for payment to Provider until Provider is paid for its services to me. As such, I acknowledge and understand that if my health insurance company sends payment to me and payable to me, I will sign 100% of these funds over to Provider without delay.* ***I further understand that not signing a received payment over to the Provider can be seen as criminal theft of services under the Nevada Revised Statutes Section 19-130 for conversion of said payment for my own use. In addition, if I withhold payment or convert payment for my own use and do not pay the Provider, I agree that I am guilty of the crime of theft of services and am liable and otherwise responsible in the event of a civil lawsuit against me from the Provider.***

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Patient Signature/Legal Guardian: Date:

_____ _____

Print Patient/Legal Guardian Name: Witnessed By:

_____ _____

Relationship to patient: Signed (Witness) Date:

Address:

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