**Logo

Description automatically generated**

**ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize and request that payment of benefits by my primary insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and my secondary insurance (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be made directly to Faebris Medical & Community Education, LLC for services rendered to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I will be responsible for all charges not covered by this assignment.

In addition, I authorize Faebris Medical & Community Education. LLC to disclose any and all written information to the above-named insurance company(s) and/ or its designated representatives, at the determination of Faebris Medical & Community Education, LLC. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Faebris Medical & Community Education, LLC; its officers, agents, employees, and any clinical staff associated with my case from all liability that may arise because of disclosure of information to the above-named insurance company(s) or their designated representatives.

**By signing this assignment of benefits and release of information I acknowledge:**

1. I am aware and understand that this authorization will not be used unless the above-named insurance company(s) or their designated representatives request record of information for reimbursement purposes; or seek to take action in reference to payment for treatment services.
2. I agree to participate and assist Faebris Medical & Community Education, LLC or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of federal and state statutes, rules and regulations that provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time, except to the extent that action has been taken in reliance thereof.
5. Faebris Medical & Community Education, LLC is acting in filing for insurance benefits assigned to the patient and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. Erogen Enterprises, Inc. is contracted by Faebris Medical & Community Education, LLC for billing and collection purposes. They will provide billing services.
7. Faebris Medical & Community Education, LLC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan’s documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Faebris Medial & Community, LLC shall be entitled to the full amount of its charges without offset.
10. I acknowledge receipt of a completed and signed copy of this assignment and release form.

**I acknowledge receipt of a completed and signed copy of this assignment and release form.**

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**