



Board-Certified Orthopaedic Surgeons
Robert A. Kayal, MD, FAAOS
Edward C. Friedland, MD, FAAOS
Lori G. Weiser, MD, FAAOS

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for product received.

In certain circumstances, insurance company may send check for services provided directly to the patient or the guarantor. In such cases, the patient and the guarantor agrees to endorse and forward such a check to KAYAL ORTHOPAEDIC CENTER, P.C. If the patient deposits such a check into a personal account, the patient and guarantor agrees to immediately send a check for the equivalent amount to KAYAL ORTHOPAEDIC CENTER, P.C.

ORGANIZATION
KAYAL ORTHOPAEDIC CENTER, P.C.
385 South Maple Avenue, Suite # 206
Ridgewood, NJ 07450

Name of person signing below (print): _____

Relationship to insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____