



Saint Louis
GYNECOLOGY & ONCOLOGY

Assignment of Benefits Form

Name of Insured (print): _____

Social Security Number: _____

Assignment of Benefits

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 that organization.

Statement of Confidentiality

I authorize the release of necessary medical information to St. Louis Gynecology & Oncology, LLC for the purpose of processing this or any related insurance claims. I also give St. Louis Gynecology & Oncology, LLC the authority to make available any requested documents contained in my file to myself and/or other health care providers involved in the treatment of my condition.

Agreement

I understand that I am financially responsible for payment of this account regardless of insurance or third party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any agency or collection fee and/or court costs. 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.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

ORGANIZATION
St. Louis Gynecology & Oncology, LLC.
11652 Studt Ave.
St. Louis, MO 63141

Name of person signing below (print) _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____