Internal Medicine Associates
8895 Broadway • Merrillville, Indiana 46410 • (219) 738-2081 Fax (219) 736-4658

Assignment of Benefits and Financial Responsibility Form

Assignment of Benefits and Authorization to Release Medical Information: I hereby assign to Internal Medicine Associates, LLC (IMA) any insurance or other third-party benefits available for health care services provided to me. I understand that IMA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to IMA, I agree to forward to IMA all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

I authorize the release of medical information which may include psychiatric, HIV/AIDS, sexually transmitted disease, and substance abuse required by my insurance carriers or its designated review agency in order to determine benefits to which I may be entitled. This authorization may be revoked by me at any time in writing.

_____ _____ _____

Signature of Patient or Legal Representative Date Relationship to Patient

Medicare Patients

_____ _____

Name of Beneficiary HIClaim Number

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by or in Internal Medicine Associates. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____ _____

Signature of Patient or Legal Representative Date Relationship to Patient