# Assignment of Benefits Form

Covina Ear, Nose & Throat Medical Group Inc.
James G. Williams, M.D.
202 W. College St.
Covina, CA 91723

Date:_____
Patient:_____
Insurance Name:_____
ID#:_____
Group#:_____

I, _____(patient's name), understand that services rendered to me by Covina Ear, Nose & Throat Medical Group are my financial responsibility and that the Provider will bill my insurance company, _____(Insurance Company Name) as a courtesy. I authorize my insurance company to pay my benefits directly to Covina Ear, Nose & Throat Medical Group, James G. Williams, MD, and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____(InsuranceCompany).
I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.
I also understand that should my insurance company send payment to me, I will forward the payment to Covina Ear, Nose & Throat Medical Group within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.
To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Covina Ear, Nose & Throat Medical Group to facilitate payment utilizing the credit card number on file to resolve the balance.
I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf, and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Signature of Policy Holder
_____

Patient/Guardian Printed Name
_____