Assignment of Medical Benefits
Financial Responsibility

Effective December 2016

Summary
An Assignment of Medical Benefits ("AOB") is an arrangement by which a patient requests that his or her health insurance benefits be made directly to a designated person or facility, such as a physician or hospital.

Insurance Authorization and Assignment of Medical Benefits:

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to Susan Ramirez, MD d/b/a TruCare, LLC, authorizing this transfer of payment from the insured to the healthcare provider, Susan Ramirez, MD d/b/a TruCare, LLC.

I, _____, herby absolutely authorize TruCare to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payments be sent directly to TruCare I understand that it is the policy of TruCare to bill the insurance company that I provide to TruCare, whether TruCare is in/out of network. I understand that any services not covered by my insurance company are my sole financial responsibility.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied TruCare with the up-to-date and correct insurance identification card(s) as well as supplied TruCare all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied within may result in denial of payment(s) to TruCare and resubmitted claims with corrected updated information that are still denied due to the fact that the corrected information was not supplied in a timely fashion to TruCare and I understand that it will be my responsibility to pay TruCare for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney or collection agency for collection or taken to court, I agree to pay any collection fees, reasonable legal fees (25% is deemed reasonable), court costs, and other expenses incurred as a result of said collection or court date, all actions having a venue of Lake County, Indiana, other venues notwithstanding. Further, I understand that there is a $30.00 fee for returned checks and a late payment charge not to exceed 1.5% applies to any balance carried forward to next month's bill.

I understand that TruCare will report to commercial credit bureaus when an account becomes delinquent. Accounts with zero payments within thirty (30) days of the statement date are considered delinquent. TruCare will report a delinquent account to the credit bureau if they do not

receive a payment within sixty-two (62) days of the date of the initial debt notification letter. All delinquent accounts are reported as a "collection account" on the consumer credit report. The debt will remain as a collection account while on the credit bureau report; however, any subsequent payment activity is reported to the credit bureaus on a monthly basis.

I certify that the information I have reported with regard to my insurance coverage is correct and I herby authorize TruCare, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Acknowledgement:

My signature below indicates that I have read this Notice, that I have been provided with a copy, and that I understand that I can request a copy of this Notice in the future.

Signature (Patient or other authorized person)	Date
Printed Name	Date of Birth
Relationship to Patient	Signed (Witness)
Address, City, State, Zip	