North Pointe Psychiatry, PA
Asad Islam, MD
Assignment of Insurance Benefits for Payment from Your Insurance Carrier

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Primary	**Secondary**
Carrier Name: _____	Carrier Name: _____
ID#:_____	ID#:_____
Group Name/Number: _____	Group Name/Number: _____
Policy #:_____	Policy #:_____
Ins. Co. Phone #: (_____) _____	Ins. Co. Phone #: (_____) _____
Insure Party Information (If other than Patient):	Insure Party Information (If other than Patient):
Name: _____	Name: _____
Date of Birth: _____/_____/_____	Date of Birth: _____/_____/_____
Address: _____	Address: _____
SS#:_____ Sex: ☐ F ☐ M	SS#:_____ Sex: ☐ F ☐ M
Insured's Employer: _____	Insured's Employer: _____
Relationship to Patient: _____	Relationship to Patient: _____

Consent to Release Claims Information and Assignment of Benefits:

- I hereby assign, transfer and set over to North Pointe Psychiatry, PA all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company (ies)

- I hereby consent for North Pointe Psychiatry, PA any of its employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.

- I understand insurance billing is a service provided as a courtesy, and that I am at all times personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to North Pointe Psychiatry, PA. I also acknowledge I am responsible for any deductible, co pay, or other balance not covered by my insurance carrier.

- I request Payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by North Pointe Psychiatry, PA, including physician services. 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/Guardian/Responsible Party Date