Assignment of
Benefits and Financial Responsibility Form

Assignment of Benefits and Claims I hereby assign and transfer to Zenu Center for Endocrinology, Metabolism and Weight Management, LLC, all of my rights, title and benefits payable by my insurance carrier or other payor for services performed by Zenu Center for Endocrinology, Diabetes and Weight Management, LLC. We have a 50$ cancellation fee if your appointment is cancelled 24 hours prior to the scheduled time.

I hereby authorize Zenu Center for Endocrinology, Metabolism and Weight Management, LLC to submit a claim to my insurance carrier, intermediary or other payor for all services rendered and to exercise any appeals and other rights under my policy on my behalf. I authorize and assign to the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or in my name, including the arbitration/dispute resolution process, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor or third party. This authorization includes the right to assignment to pursue declaratory relief or other legal remedies. I authorize Zenu Center for Endocrinology, Metabolism and Weight Management, LLC to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits and all other insurance benefits through the carriers themselves, plan administrator, payor or third party. I authorize Zenu Center for Endocrinology, Metabolism and Weight Management, LLC to obtain an attorney to represent me directly in appealing a claim to the State Health Benefits Commission for all state plans. I authorize Zenu Center for Endocrinology, Metabolism and Weight Management, LLC to obtain an attorney to represent me directly in appealing a claim to the appropriate Federal Agency for all federal plans. I authorize Zenu Center for Endocrinology, Metabolism and Weight Management, LLC act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. I direct my insurance carrier, payor, or its intermediaries, to issue a payment check directly to Zenu Center for Endocrinology, Metabolism and Weight Management, LLC. If the insurance company or payor will not directly pay Zenu Center for Endocrinology, Diabetes and Weight Management, I authorize and direct that the company send all checks and copies of Explanation of Benefit forms in connection with the services of Zenu Center of Endocrinology, Metabolism and Weight Management, LLC, as my agent for delivery of said items and use. I hereby authorize Zenu Center for Zenu Center for Endocrinology, Metabolism and Weight Management, LLC to release all information necessary regarding services rendered to my insurance company or other payor and my referring physician. I understand and agree that regardless of my assignment of benefits, I am legally and financially responsible for the allowed by insurance carrier charges for services rendered by Zenu Center for Endocrinology, Metabolism and Weight Management, LLC. I understand that certain patient responsibility payments such as copayments/co-insurance are due in full at the time of service.

I agree to cooperate, aid and assist Zenu Center for Endocrinology, Metabolism and Weight Management, LLC in procuring all possible insurance benefits. Consent to Disclosure I authorize Zenu Center for Endocrinology, Metabolism and Weight Management, LLC and its agents and attorneys to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to Zenu Center for Endocrinology, Metabolism and Weight Management, LLC about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition. Failure to Comply I understand that failure to comply with my responsibilities under this form will result in my account remaining active. I guarantee payment of all said charges incurred. In the further event that the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all reasonable attorney, collection agency fees and costs incurred in collection. The undersigned has read and understands the above terms.

Patient's Name: _____

Dated:
_____