

RECOVERY CARE

PATIENT INFORMATION, ASSIGNMENT OF BENEFITS & HIPAA ACKNOWLEDGMENT

Last Name _____

First Name _____

Middle Initial _____

Date of Birth (MM/DD/YYYY) _____

Street Address _____

City _____

State _____

ZIP Code _____

Insurance Plan _____

Member ID _____

Assignment of Benefits / Authorization for Release of Information

I authorize payment of Medicare, Medicaid, and/or private insurance benefits directly to Recovery Care for covered services provided to me. I authorize Recovery Care to release to Medicare, Medicaid, other governmental health programs, and/or my private insurer the information reasonably necessary to determine benefits, process claims, and obtain payment for services. I understand that I remain responsible for charges not covered by my insurer or benefit plan, subject to applicable law and payer requirements.

Patient Signature _____

Date _____