SWGA SWE
Southwest Gastroenterology Associates P.C.
7788 Jefferson St NE Albuquerque, NM 87109
Phone: 505-999-1600 Fax: 505-999-1650
Southwestgi.com

ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. You agree to fill out and complete all necessary forms that may be required for your particular insurance carrier. In some cases, the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is paid.

Assignment of Benefits
I hereby assign all medical and mental health benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to Southwest Gastroenterology Associates for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **SWGA** to:

1. Release any information necessary to insurance carriers regarding my therapy and services. I understand that my healthcare provider may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and process claims for payment. This information may include, but is not limited to, types of service, dates of service, times of service, diagnosis, treatment plans, progress of treatment, and, at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of the **SWGA** Notice of Privacy Practices.
2. Request payment of insurance benefits be made directly to Southwest Gastroenterology Associates for services performed.
3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner or other appropriate state agency if payment for services is not timely received. I have requested treatment services from SWGA on behalf of myself and/or my dependents. I understand that by making this request, I will become fully financially responsible for all charges incurred during the authorized treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient/Guardian: _____ Date: _____