	Name: CSN: Date of Service:

Assignment of Benefits/Release of Information (Outpatient)

Most patients will have some financial responsibility for the services that they receive from Partners HealthCare and/or its associated physician groups depending on their insurance coverage. This document highlights that responsibility you may have. Related to the services you will receive, it also authorizes Partners and/or its associated physician groups to disclose information from your medical records as it is deemed reasonably necessary, in a HIPAA compliant manner, for claims processing and payment.

If you are a member of a Managed Care Plan, then it is your responsibility to ensure that you adhere to your plan's requirements in your member agreement to obtain a valid referral or authorization from your Primary Care Provider (PCP) or insurance carrier. If you are seeing a PCP that is not listed as your PCP with your health plan, your health plan may deny coverage for that visit and you will be financially responsible, with the exception of MassHealth Managed Care members.

If you do not have active insurance coverage, or you are receiving services that are not covered by your health insurance benefit plan, you are considered a self-pay patient and responsible for balances related to the services you receive.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT.

1) I have read and understand the information provided in this form above.

2) I authorize the HIPAA compliant release of my medical records, including all HIV/AIDS related testing and treatment information, to my health insurer for claim processing and payment purposes.

3) I authorize that my insurance benefits are to be paid directly to Partners HealthCare and/or its associated physician groups. I acknowledge that I am responsible for all balances that are deemed by my health insurance plan to be my responsibility including deductibles, co-insurance, co-payments and other services not covered by my plan. If I do not have active insurance, I am responsible for the balances related to the services I receive.

I understand that if I provide a mobile number, I authorize that Partners Healthcare and/or its associated physician groups may contact me at this number for matters related to my care, including treatment, payment of my bill, or healthcare operations. It is my responsibility to notify Partners Healthcare and/or its physician groups if my mobile number changes.

Patient/Guarantor Signature:_____.

Print Name:_____.