KAUFMAN ALLERGY
ASTHMA AND IMMUNOLOGY CENTER

KAREN KAUFMAN, DO FAAAAI
Allergist Immunologist

KaufmanAllergy.com
Info@KaufmanAllergy.com

Assignment of Benefits

Originally effective: 1/1/2021

Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Kaufman Allergy Asthma and Immunology, PLLC for services rendered to the patient. I hereby authorize payments directly to Kaufman Allergy Asthma and Immunology, PLLC, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Kaufman Allergy Asthma and Immunology, PLLC for services rendered to me during the applicable periods of medical care.

For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Kaufman Allergy Asthma and Immunology, PLLC for any services furnished to me during the applicable periods of medical care.

Unauthorized, Non-covered, or Out of Plan Services:
I understand and acknowledge the following:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services or has not authorized these services they will not pay and I agree to pay for these services.
- If Kaufman Allergy Asthma and Immunology, PLLC may not accept or may be out of network with my health insurance.
- In the case of out of plan/network physician services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

By signing this consent, I understand that Kaufman Allergy Asthma and Immunology, PLLC, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about

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outstanding balances through various methods including the use of phone calls, voice messages and/or automated calls at any phone number I provide to Kaufman Allergy Asthma and Immunology, PLLC. I also agree that in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Kaufman Allergy Asthma and Immunology, PLLC. I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient visits to Kaufman Allergy Asthma and Immunology, PLLC unless specifically cancelled in writing by me. I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Kaufman Allergy Asthma and Immunology, PLLC.

Patient's name | Date of Birth

Signature of Responsible Party (guarantor) | Relationship to Patient