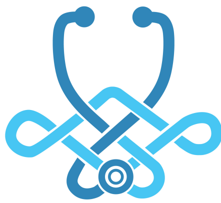

Karma Wellness Center
242 N. Main Street
New City NY 10956
T: 845-825-3362
F: 845-354-8555

Patient: ______________________________
MR #: ______________________________
Date: ______________________________

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company ________ _________________, and my secondary insurance (if any) ____________________ be made directly to Karma Wellness Center for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Karma Wellness Center to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of the physician seen onsite. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Karma Wellness Center, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. **I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.**
2. **I agree to participate and assist Karma Wellness Center or its designated representatives with any appeal process necessary to collect payments for services rendered.**
3. **I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.**
4. **I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.**
5. **Karma Wellness Center is acting in filing for insurance benefits assigned to claim for date of service rendered and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).**
6. **A firm contracted by Karma Wellness Center for billing and collection purposes may do billing.**
7. **Karma Wellness Center is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.**
8. **Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.**
9. **Karma Wellness Center shall be entitled to the full amount of its charges without offset.**

I acknowledge receipt of a completed and signed copy of this assignment and release form.

Patient Signature: ____ **Date:** ________________

Staff Signature: ____ **Date:** ________________

Staff Print Name - Credentials