MORRIS SUSSEX FAMILY PRACTICE

694 ROUTE 15 SOUTH * SUITE 103 * LAKE HOPATCONG, NJ 07849
973-663-8899
DR. ANTHONY J. LUCATORTO, DO

Release and Assignment of Benefits

Please complete the following information carefully and sign where indicated

I, the undersigned, herby authorize the release of all information necessary to any entities to secure the payment of benefits submitted for services rendered by my provider on behalf of myself and/or my dependents. I understand information will be provided to Morris Sussex Family Practice billing to secure the payment of benefits. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, undersigned, have coverage with the insurance companies listed on the Patient Registration Form and assign directly to Dr. Anthony J. Lucatorto all claim benefits, if any, otherwise payable to Dr. Anthony J. Lucatorto for all services rendered.

I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my provider, whether or not paid by the insurance company notwithstanding any pending legal action.

If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange prompt payment to clear my bill. I understand that payment is due upon receipt of my monthly statement. Interest charges will be added to outstanding balances after 90 days at 2% per month. I understand that I will be legally responsible for all collection costs involved with the collection of my account, including any fee for returned checks.

I have read ALL the information on this sheet. I certify this information is true and correct to the best of my knowledge. I will also notify the provider of any changes in my health status or information reflected on the Patient Registration Form.

_____ _____

Patient or Legal Guardian Printed Name Date

_____

Patient or Legal Guardian Signature