**MEDICARE PATIENT CONSENT / ASSIGNMENT OF BENEFITS FORM**

[Practice Address, City, State, Zip Code]

Practice Phone Number: [Practice Phone Number]

**STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT / ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medicare and/or private or commercial insurance benefits to me or on my behalf be made to [Practice Name] for iovera° treatment services furnished to me by [Practice Name]. I authorize any holder of medical or other information about me to release to Medicare and/or my private or commercial insurance, and its agents, any information needed to determine these benefits for related services. I understand that [Practice Name] reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. In the event medical necessity no longer exists or my payer no longer deems my treatment to be covered, I understand I will be held responsible for payment to [Practice Name]. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible. I acknowledge receipt and understanding of my Patient/Client Bill of Rights, Notice of Privacy Practices, and Complaint/Grievance Process. I acknowledge that there are no applicable product warranties associated with iovera° treatment services. In addition, I agree that [Practice Name] may contact me in the future, via telephone, email, mail or other means of communication, regarding my services or payment.

Patient's Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Patient’s Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICARE Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

Other / Additional Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: If the patient is physically or mentally unable to sign, a representative may sign on the patient’s behalf. In addition, the representative’s signature, date signed, representative's name (print), address, relationship to the patient and reason why the patient cannot sign must be listed below.

Representative’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Representative’s Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason Patient Cannot Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are unable to fill this form out in person while at your practice, please mail this original completed form, not a copy, within 5 days of receipt to the address above.