TAKE TWO HEALTH PC
2503 Walnut Street #200
Boulder CO 80302
303-557-2250
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Leto Quarles MD

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my Medicare Part B and/or Health First Colorado Medicaid be made directly to TAKE TWO HEALTH PC for services furnished to me or my dependent.

If I have conventional Medicare Part B, they will be billed as my Primary insurer.
If I have ONLY Health First Colorado Medicaid, they will be billed as my Primary insurer.
If I have Medicare Part B as my Primary insurer, and Health First Colorado Medicaid as my secondary insurer, each will be billed according to their assigned roles.

I understand that TAKE TWO HEALTH PC does NOT participate with any commercial health plans or other third party payors. Other than Medicare Part B and Health First Colorado Medicaid, all other payments are the responsibility of the Patient-Member.

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 TAKE TWO HEALTH PC to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of TAKE TWO HEALTH PC. Such disclosure shall be for reimbursement purposes for those services received. I hereby release TAKE TWO HEALTH PC, 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 TAKE TWO HEALTH PC 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 HIPAA Federal and State Statutes, 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. TAKE TWO HEALTH PC is acting in filing for insurance benefits assigned to TAKE TWO HEALTH PC and it can assume no responsibility for guaranteeing payment of any charges from my insurer.
6. A firm contracted by TAKE TWO HEALTH PC for billing and collection purposes may do billing.
7. TAKE TWO HEALTH PC 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. TAKE TWO HEALTH PC 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.

_____ _____
Signature of Patient or Legal Representative Date