WOUND CARE INSTITUTE OF OCEAN COUNTY

Assignment of Benefits, Release Form & Financial Policy

Patient Name: ____

Primary Insurance: ____

Policy Number :________________________________ Group Number: ________________

Subscriber Name: ______________________________ Date of Birth: ________________

Subscriber Employer: ____

Secondary Insurance: ____

Policy Number : ______________________________ Group Number: ________________

Subscriber Name: _____________________________ Date of Birth: _________________

Subscriber Employer: ____

Do you have Medicare Part D or prescription drug coverage? YES NO

AUTO ACCIDENT: YES NO

WORKERS COMP: YES NO

***** If either of the two above questions apply to you, please fill out the reverse side of this form. *****

I hereby instruct and direct the mentioned insurance companies to pay by check, made out and mailed to:
Wound Care Institute Of Ocean County
54 Bey Lea Road, Suite 1
Toms River, NJ 08753
for the professional or medial expense benefit allowable, otherwise payable to me.
This is a direct assignment of my rights and benefits under this policy.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered
- I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _________________________________ Date: ____________________

Relationship (if not self): ____

****

For Office Use Only:

□ Insurance Card & ID Scanned ________ by ________
Date Initials

WOUND CARE INSTITUTE OF OCEAN COUNTY

AUTO ACCIDENT / WORKERS COMPENSATION

Patient Name: ____

AUTO/COMP Insurance Carrier: ______________________________

Claims Address: ____

____

Claim Number: ____

Date Of Accident/Loss: _____________________________________

Adjusters Name & Telephone Number: _________________________

____

Adjusters Fax Number: ______________________________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature: ____

Relationship (If not self):___________________________________

Date Signed: ____