FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

Rivkin Addiction Medicine, PLLC • Aaron Rivkin, MD

19100 Goddard Road, Suite 1, Allen Park, MI 48101 • Phone: 313-315-6922

Patient Name: _____	Date of Birth: _____	Date: _____

A. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Rivkin Addiction Medicine, PLLC to bill my insurance carrier(s) on my behalf for services rendered, and I assign my insurance benefits directly to Rivkin Addiction Medicine, PLLC. I authorize my insurance carrier to make payment directly to Rivkin Addiction Medicine, PLLC for covered services.

I authorize the release of any health information to my insurance carrier(s) solely as necessary to process and adjudicate claims for services rendered at this practice.

B. PATIENT FINANCIAL RESPONSIBILITY

I understand and agree to the following:

- I am financially responsible for all charges incurred at Rivkin Addiction Medicine, PLLC, regardless of my insurance coverage or the outcome of any insurance claim.
- My insurance coverage does not guarantee payment. I am responsible for verifying my benefits prior to receiving services.
- I am responsible for all deductibles, copayments, coinsurance, and any amounts deemed non-covered by my insurance carrier, including services determined to be not medically necessary by my insurer.
- If I do not have insurance or choose to pay out of pocket, payment is due at the time of service unless other arrangements have been made in advance with this practice.
- If my insurance carrier pays me directly for services rendered by this practice, I agree to promptly forward those payments to Rivkin Addiction Medicine, PLLC.
- Accounts with outstanding balances may be subject to collections. I understand that collection costs, including reasonable attorney fees, may be added to my balance if collection action becomes necessary.
- I agree to promptly notify this practice of any changes to my insurance coverage, address, or contact information.

C. MEDICARE PATIENTS — ADDITIONAL ACKNOWLEDGMENTS

If I am a Medicare beneficiary, I additionally acknowledge the following:

- I authorize Rivkin Addiction Medicine, PLLC to submit claims to Medicare on my behalf for all covered services.
- I understand that Medicare pays only for services it determines to be medically necessary. If Medicare determines that a service is not covered, I may be billed for that service. I will be notified in advance via an Advance Beneficiary Notice (ABN) for any service that Medicare may not cover.
- I authorize Medicare to release information about my health care to Rivkin Addiction Medicine, PLLC as necessary to determine benefits or the benefits payable for related services.
- I understand that I have the right to request an itemized statement of services within 30 days of receiving a Medicare Summary Notice.

D. SELF-PAY PATIENTS

If I am paying out of pocket (self-pay), I acknowledge the following:

- Payment in full is due at the time of service unless a payment plan has been arranged in advance with this practice.
- I understand that I have the right to receive a Good Faith Estimate of expected costs for non-emergency services. I may request a Good Faith Estimate at any time.

- If I have insurance but choose to pay out of pocket for a specific service and request that the service not be billed to my insurer, I understand that this practice will honor that request as permitted by law.

E. BILLING INQUIRIES AND DISPUTES

All billing inquiries should be directed to Rivkin Addiction Medicine, PLLC. If you believe there is an error on your bill or have a question about a charge, please contact us before any payment is due. We will work with you to resolve billing questions promptly.

Billing is managed by Physicians Revenue Group (PRG) on behalf of Rivkin Addiction Medicine, PLLC. PRG may contact you regarding outstanding balances or insurance questions. PRG is authorized to communicate with you and your insurer on behalf of this practice.

Billing Contact: Rivkin Addiction Medicine, PLLC • Phone: 313-315-6922

F. SIGNATURE

By signing below, I confirm that I have read and understand this Financial Responsibility and Assignment of Benefits Agreement and agree to its terms. I certify that the insurance information I have provided is accurate and complete to the best of my knowledge.

Patient Signature	**Guardian / Representative (if applicable)**
X _____ Printed Name: _____ Date: _____	X _____ Printed Name: _____ Relationship: _____ Date: _____
If patient was unable to sign, document reason: Reason: _____ Staff Initials: _____	