Paul M. Figlia, MD, PA

Board Certified Plastic Surgeon

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MEDICAL AND ASSIGNMENT OF BENEFITS RELEASE FORM

I, _____, authorize Paul M. Figlia, MD, PA, ("My Health Care Provider"), to submit claims to my insurance carriers on my behalf. I also authorize assignment of all health insurance benefits to which I am entitled to by my insurance plan(s) to be paid directly to My Health Care Provider for any services rendered. I understand that the contract with any insurance carrier is between me and the specified carrier(s). I also understand that I am financially responsible for all charges, whether or not I am insured at the time of service including deductibles, coinsurance, co-payments, and benefit services that are out-of-network, denied and/or not covered by my health insurance plan. In the event that my account is unpaid and/or neglected, it will be turned over to the attorney's office and legal action may be taken. Legal expenses, as well as interest, will be added onto any unpaid balances.

I hereby authorize and direct my insurance carrier to make all such payments directly to My Health Care Provider, Paul M. Figlia, MD, PA, for all claims for such services submitted. Such payment should be forwarded by my insurance carrier directly to My Health Care Provider at the above address, in the form of a check payable to Paul M. Figlia, MD, PA. I understand and agree that, if the check is made payable to myself, the subscriber or Paul M. Figlia, MD, PA and me, that I promptly will take such action as requested by my Health Care Provider to endorse the check so that Paul M. Figlia, MD, PA can be paid for his services rendered.

I authorize My Health Care Provider to release to my insurance carriers or their authorized agents any information needed for this claim or a related claim. I authorize my insurance company to release detailed copies of the Explanations of Benefits to My Health Care Provider upon their request. I also authorize the release of any adjustments or reviews by the insurance company to the doctors upon their request. This is inclusive of any audits of the doctor's bill requested by my insurance carrier. This assignment and authorization in no way releases me from my responsibilities indicated above, and imposes any obligation on Paul M. Figlia, MD, PA.

I give permission for photographs to be taken and used for medical purposes, as well as any other purpose that my physician deem proper in the interest of medical education, knowledge, or research. I understand that in any such use I shall not be identified by name. I further grant permission for the use of my records, illustrations and photographs for purposes required by the American Board of Plastic Surgery, Inc.

I HEREBY SIGNIFY THAT I HAVE PROVIDED INFORMATION THAT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT I AM AWARE OF MY RESPONSIBILITIES REGARDING RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS. A PHOTOCOPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALIED AS THE ORIGINAL.

PATIENT'S NAME (PRINT) _____

PATIENT/INSURED'S SIGNATURE _____ DATE _____

PATIENT/INSURED'S SOCIAL SECURITY # _____ - _____ - _____