BANISTER NUTRITION LLC

Assignment of Benefits

I acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only.

I hereby instruct and direct the *insurance company designated below to issue direct payment to Banister Nutrition for the medical expenses allowed under my current insurance policy. Such payment shall be applied toward the total charges for services rendered on my behalf at Banister Nutrition that are invoiced to my insurance company. This assignment is a direct assignment of my rights and benefits under my insurance policy.

I agree to pay Banister Nutrition, in timely manner, any balance of medical charges and expenses over and above the amount of allowed insurance payment, including charges for any services not covered by insurance, expenses, and any deductibles that are required pursuant to the above mentioned insurance policy.

If my insurance changes after my initial appointment, it is my responsibility to notify BN immediately and provide a copy of the new insurance card. I agree if I do not notify BN in advance of any change in insurance this could result in me being responsible for my balance.

Patient/Guardian Signature **Date**

HIPAA

Please read Banister Nutrition HIPAA – Notice of Privacy Practice in our office or website at https://banisternutrition.com/new-patients/

Please acknowledge by signing below, that you have read the HIPAA and understand your rights according to the HIPAA.

Patient/Guardian Signature **Date**