PETER T. HETZLER
MD, FACS
200 White Road, Suite 211
Little Silver, NJ 07739

Patient Financial Responsibility and Assignment of Benefits

*Patient/Guarantor agrees to assign benefits to Peter T Hetzler MD FACS LLC (Dr. Hetzler). You authorize and assign payment to Dr. Hetzler of any and all insurance benefits to which you are otherwise entitled for services rendered.
* Dr. Hetzler agrees to accept the maximum amount your insurance carrier(s) allows for your claim. You will be billed for any deductible, coinsurance, or copayment amounts applied to your claim. You are also responsible for immediately forwarding any insurance payments or insurance correspondence related to the claim to this office.
*Because **Dr. Hetzler is a non-participating provider** with your insurance plan, you may receive an insurance check(s) directly for services rendered. Please do not cash the insurance check. Please endorse the insurance check and forward it and a copy of the explanation of benefits to: Peter T Hetzler MD FACS LLC 200 White Road Suite 211 Little Silver, NJ 07739
*Several insurance carriers will not correspond with non-participating providers directly. You must furnish a copy of any correspondence sent directly to you.
*If you do not forward the insurance payment, explanation of benefits, or claim-related correspondence within 90 days, you may be held responsible for the full charge plus recovery of all costs and legal fees. Delinquent Accounts may be charged for recovery of all costs and legal fees and may be charged interest at one and one half percent (1 ½%) per month for outstanding balances. You may be charged $34.00 for any check that is returned as not payable by your bank.
*You may be held responsible for the full charge amount including amounts in excess of your insurance plan allowances if your insurance denies for non-compliance with insurance carrier requests, if your policy benefits have been exhausted, or if you fail to provide accurate insurance information.

Please sign below indicating your acknowledgment of and agreement to the terms and conditions stated above. Your signature represents that you fully understand this agreement and have received any needed assistance interpreting this agreement.

_____ _____
Patient/Guardian Signature Date

If any portion of this form is found to be invalid, the remainder shall remain in effect.
A photocopy of this shall be deemed as valid as the original.

AUTHORIZATION FOR HEALTH INOFRMATION DISCLOSURE (HIPAA RELEASE)

Please disclose the following protected health information to:

Peter T Hetzler MD FACS LLC
200 White Road Suite 211
Little Silver, NJ 07739-1150

This request is for the purpose of collecting payment of medical bills and includes the disclosure of any and all records relevant to the processing and/or payment of the medical claim(s) for services rendered by Peter T Hetzler MD FACS LLC. I understand I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer at the address above. I understand that the revocation does not apply to information that has already been released in response to this authorization. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary.

_____ _____
Patient/Guardian Signature Date

Revised 02/17/2016