Home Products Healthcare

Assignment of Benefits and Release of Information

I request that any and all benefits payable to me under the conditions of my medical insurance program be made to Home Products for Seniors, Inc. on any and all bills for equipment and/or services furnished to me by Home Products for Seniors, Inc. I also further hereby authorize Home Products for Seniors, Inc. to release any and all information required in order that claims be processed.

I also consent to the release of any and all medical information to Home Products for Seniors, Inc. for my continued treatment, payment and their healthcare operations as necessary to process these claims. I request payment of benefits to the party who accepts assignment.

I understand that I am ultimately responsible for payment of any charges not covered by my insurance company.

Patient Signature:_____ Date:_____

Print Patient Name:_____

If the patient if unable to sign, please complete this section

Medical reason patient cannot sign: _____

Print Name of authorized Representative: _____

Relationship to Patient: _____

Authorized Signature:_____ Date: _____

1250 West Dorothy Lane, Suite 303 ■ Dayton, Ohio ■ 45409
www.homeproductshealthcare.com
(800) 425-1101 ■ info@hp4s.com