



# violet health®

## Infusion Care

### ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY FORM

#### PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Insurance ID: \_\_\_\_\_

#### ASSIGNMENT OF BENEFITS AND RIGHT TO PAYMENT

I, the undersigned, hereby irrevocably assign to Violet Health Infusion Center ("Provider") all of my rights, benefits, and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan"). This assignment applies to all medical services provided by Provider, its employees, and agents.

I understand that this document is a direct assignment of my rights and benefits under my Plan. I expressly direct and instruct my insurance company to make payment directly to the Provider for all services rendered. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make the check payable to me and mail it to:

**Violet Health**  
**2256 Orchard Lake Rd**  
**Sylvan Lake, MI 48320**

I agree and understand that any funds I receive from my insurance company for services rendered by Provider will be immediately signed over and sent directly to Provider.

#### FINANCIAL RESPONSIBILITY

- I acknowledge and agree that I am responsible for all charges for services provided which are not covered by my Plan or for which I am responsible for payment under my Plan.
- I understand that copayments, deductibles, and non-covered services are due at the time of service.
- I agree to pay any balance remaining after payment of amounts covered by insurance within 30 days of notification.
- I understand that I am responsible for any expenses incurred in the collection of my account in case of default, including reasonable attorney fees and court costs.

#### AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Provider and/or its agents to:

- Release any medical or other information about me to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents as needed for this or any related claim.



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- Contact my insurance company to obtain any relevant information about my coverage, benefits, or claim payments.
- Request payment of medical benefits to the Provider for services rendered.
- Appeal claims on my behalf if necessary.

### CONSENT FOR TREATMENT

- I authorize Provider and its medical professionals to provide medical care and treatment, including but not limited to infusion therapy and related services.
- I understand that my treatment may require multiple visits, and this authorization will remain in effect throughout my course of treatment.
- I acknowledge that no guarantees have been made regarding the outcome of treatment.

### ACKNOWLEDGMENT

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. A photocopy or digital copy of this Assignment shall be considered as effective and valid as the original.

Patient/Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient (if not patient): \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

Insurance Verification: \_\_\_\_\_

Authorization Number: \_\_\_\_\_

Verified By: \_\_\_\_\_

Date: \_\_\_\_\_