Allina Health
ASSIGNMENT OF BENEFITS FORM

Assignment of Benefits: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by Allina Health, including physician services, or by any provider under contract with Allina Health or participating in a provider network in which Allina Health or its affiliates participate.

Important Information for Patients. I received the material on each line initialed below.

_____ Notice of Privacy Practices (unless received during previous visit)
_____ Federal and State Patient Rights Information
_____ Health Care Directive Brochure
_____ Important Message from Tricare/Champus (inpatient visit only)

_____ _____
Signature of Patient, or if Patient is unable to sign, a Representative of the Patient — Date/Time

_____ _____
Relationship to Patient (if patient is unable to sign) — Reason Patient Unable to Sign

Guarantee and Agreement to Pay

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that 6% interest per year may be added if the account balance goes to a collection agency.

_____ _____
Patient, Legal Representative or Guarantor Signature — Date/Time

☐ **Directed by Patient to sign on their behalf (having read this document to them)**