

**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)**

Allina Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-506-4595.

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-506-4595.



**ASSIGNMENT OF  
BENEFITS FORM**

PATIENT LABEL