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## Assignment of Benefits Form

### • Authorization and Release

I authorize the release of pertinent information necessary to process my medical claim. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance and any other health plans to **SOUTHERN VERMONT AUDIOLOGY** for services rendered. The assignment will remain in effect until revoked by me in writing. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

I also authorize **SOUTHERN VERMONT AUDIOLOGY** to release any and all medical information in the course of my treatment to the primary care physician provided. Also to: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### • HIPPA Statement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_