Institute
for Weight Management

Patient Name :_____

Assignment of Benefits (AOB)
Authorization Form

This Assignment of Benefits (AOB) form authorizes **Institute of Weight Management** to bill Medicare and/or other applicable insurance carriers on your behalf.
This form must be **signed, completed, and returned (or submitted electronically)** before your order or service can be fulfilled.

Patient Authorization

By signing below, I authorize each of the following:
Assignment of Benefits:
I assign all Medicare, Medicaid, Medicare supplement, and/or other insurance benefits payable for items or services furnished by **Institute of Weight Management** directly to **Hudson MD Group.**
Direct Billing:
I authorize **Institute of Weight Management** to bill Medicare, Medicaid, Medicare supplement, and/or other insurers directly for the products and services provided.
Release of Information:
I authorize the release of my medical information to Medicare, Medicaid, and other insurers and their agents as required for claim processing and payment.
Information Access:
I authorize **Institute of Weight Management** to obtain medical and other information necessary to process my claims, determine eligibility, and seek reimbursement for services and supplies rendered.
Communication Authorization:
I authorize **Institute of Weight Management** to contact me by telephone, mail, or secure electronic means regarding my medical care, services, or supplies.

Patient Financial Responsibility

I understand that I am financially responsible for any portion of charges not covered or approved by Medicare, Medicaid, or my insurance carrier, including but not limited to co-payments, deductibles, non-covered services, and any unmet portion of Medicare's annual deductible.

Signature:_____ Date:_____