BENNINGTON COLLEGE

PATIENT BILLING, CONSENT AND ASSIGNMENT

Patient Name_____ DOB_____

If policy is a Medicaid based policy, please check here ☐

Billing Address: (Where do you want the bill sent?)

Responsible party if other than self:_____

Mailing Address _____

City _____State & Zip _____

Phone _____ Relationship to Student_____

I authorize Bennington College to file insurance claims on my behalf to the company(ies) with which I have coverage as provided on the Proof of Insurance form. I also permit the release of protected medical or other information about me, which may be required for filing such claims, to the physician's billing company and to my insurance company(ies). I have a right to be notified following a breach of my unsecured PHI. I understand that I have the right to restrict certain disclosures of PHI to a health plan when I pay for treatment at issue out of pocket in full. I permit a copy of this authorization to be used in placed of the original.

I request that payment under the medical insurance program(s) be made to Bennington College for services rendered to me. I understand that I am responsible for any amount not covered by my insurance.

I understand that I have the right to revoke this consent in writing, except to the extent of action taken in reliance of this consent.

I acknowledge that I have reviewed Bennington College's Notice of Privacy Practices and that I am entitled to receive a paper copy of the Notice upon request. I understand that it is my right and responsibility to review the privacy notice, to request restrictions, and that I have the right to revoke in writing consent after reviewing the privacy notice.

Patient Signature_____ Date_____

Office Use Only:
☐Submitted to BMMS
☐Entered into PF
☐If Medicaid, copy to TS

Co-payment is expected at the time of service

Edited: 8/1/2023