



RELEASE OF BILLING & PATIENT FINANCIAL RESPONSIBILITY

PATIENT INFORMATION

Date: _____

Patient Name: _____ DATE OF BIRTH: _____

1. Authorization To Release Information For Billing

I authorize Healthier Body Institute and its staff to release any medical, personal, or billing information — including diagnoses, treatment records, BMI documentation, comorbidity history, operative notes, and pre-surgical evaluation records — to my insurance carrier(s), Medicare, MassHealth, managed care organizations, third-party administrators, and any billing or collection agents acting on behalf of the practice, as necessary to process and collect payment for services rendered.

This authorization includes information related to bariatric surgery consultations, pre-surgical evaluations (nutritional, psychological, medical clearance), surgical procedures, and all post-operative follow-up care.

A photocopy or electronic copy of this authorization shall be considered as valid as the original. This authorization remains in effect until revoked by me in writing.

2. Assignment Of Benefits

I hereby assign and authorize direct payment of all insurance or health plan benefits — including Medicare and MassHealth benefits — to Healthier Body Institute for services rendered. I understand that I am responsible for any balance not paid by my insurer, including co-payments, deductibles, co-insurance, and non-covered services.

3. Patient Financial Responsibility

I understand and agree to the following:

- I am ultimately financially responsible for all charges for services rendered, regardless of my insurance coverage or eligibility status.
- Pre-authorization is not a guarantee of payment. My insurer may deny claims after services are rendered, and I will be responsible for any denied or uncovered amounts.
- Bariatric surgery and related services may require documentation of prior supervised weight loss, psychological evaluation, nutritional counseling, and medical clearance.

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301



Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

Failure to provide required documentation to my insurer may result in claim denial, for which I remain responsible.

- If I have MassHealth (Medicaid), I understand that only covered services will be billed and that I am responsible for any non-covered portions or spend-down requirements.
- If I am uninsured or self-pay, full payment or a payment plan arrangement is required prior to or at the time of service.
- Unpaid balances may be referred to a collection agency. I will be responsible for all costs of collection, including court costs and collection agency fees.

4. Notice Of Privacy Practices

I acknowledge that I have been offered a copy of Healthier Body Institute's Notice of Privacy Practices, which describes how my health information may be used and disclosed in accordance with HIPAA and Massachusetts state law (M.G.L. c. 111, § 70E).

5. Acknowledgment

By signing below, I confirm that I have read, understood, and agree to the terms above. I certify that the insurance information I have provided is accurate and complete.

Please sign and print your name below. If the patient is a minor or unable to sign, a legal guardian must complete the guardian section.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

If patient is a minor or unable to sign:

Legal Guardian Signature: _____ Date: _____

Printed Guardian Name: _____ Relationship to Patient: _____