Assignment of Benefits

Dr. Hakan M. Usal, M.D.

By completing this form, you will help ensure payment to your health care provider under your health insurance policy or benefit plan.

I hereby assign to Dr. Hakan M. Usal ("Usal Cosmetic Surgery") my right to receive reimbursement for medically necessary health care services provided to me and/or any beneficiary under my health benefits policy. I hereby authorize and direct my insurance carrier to make all such payments directly to Dr. Usal for all claims for such services submitted on or after January 16, 2011. Payment should be forwarded from my insurance carrier directly to Dr. Usal at the address below, in the form of a check payable to Dr. Usal or, in the alternative, a check to "Usal Cosmetic Surgery" and me, as joint payee. I understand and agree that, if the check is made payable to Dr. Usal and me, that I promptly will take such action as requested by Dr. Usal to endorse the check so that Dr. Usal can be paid for services rendered. All payments should be issued directly to Usal Cosmetic Surgery at the following address:

Usal Cosmetic Surgery
P.O. Box 8
Tappan, NY 10983

In the event that Dr. Usal elects to dispute payment determinations issued by my insurance carrier, his office has permission to file appeals on my behalf. I authorize any member of his staff to act as my designated representative in this matter. I direct my insurance carrier to communicate with his office to resolve the appeal/dispute in an expeditious manner.

I understand that I am financially responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no ways releases me from this responsibility and imposes no obligation on Dr. Usal to collect money on my behalf.

I have read, understand, and agree to the above. A photocopy of this assignment shall be considered as effective and valid as the original. This assignment of benefits will be effective until revoked by me in writing. Any revocation shall have a prospective effect only.

Patients Name: _____

Patient's Social Security No.: _____

Patient/Guardian Signature: _____

Primary Insured's Signature (if different): _____

Primary Insured's Social Security No. (if different): _____

Date: _____