

## **Authorization to Release Information / Assignment of Benefits**

Please be aware that all medical information is confidential and cannot be released without your authorization. Our Notice of Privacy Practices provides specific details regarding how your information is guarded and used.

Many insurance carriers require medical information be submitted with claims. This information is used to determine medical necessity. Please give us your authorization to release related information when required or requested by your insurance company.

I, \_\_\_\_\_, do hereby authorize Nipro Diabetes Systems hereafter known as NDS to acquire from my healthcare team, any information required by my insurance company and to release any information to my insurance company acquired in the course of providing services to me. This information will be used for processing all medical claims on my behalf. I understand insurance billing is a service provided as a courtesy, and I am at all times personally responsible for any fees not paid by my insurance carrier. I further authorize my insurance company / companies to pay benefits directly to NDS. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to NDS. If NDS is denied payment in whole or in part for any reason, I personally guarantee payment for all services rendered. I also acknowledge I am responsible for any deductible, co-pay, or other balance not paid by my insurance carrier, except if I am enrolled in an approved Medicaid program.

I agree to notify NDS immediately of any changes to my insurance coverage.  
I acknowledge that I have received the Notice of Privacy Practices for Nipro Diabetes Systems.

**Patient / Guarantor Signature:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PLEASE FAX or RETURN BY MAIL**  
**Toll-Free FAX: (877) 770-5900**  
**Nipro Diabetes Systems**  
**3361 Enterprise Way, Miramar, Florida 33025**