Assignment of Benefits Form

Financial Responsibility

I hereby assign all benefits, to include medical benefits, to which I am entitled. I hereby authorize and direct my insurance carriers including auto or any other health/medical plan, to issue payment, checks, directly to Gotham Shuttle Service for transportation rendered to myself and/or my dependents, regardless of my insurance benefits, if any. **I understand that I am responsible for any amount not covered by insurance.**

I understand that insurance billing is service provided as a courtesy and that I am at all times financially responsible to Gotham Shuttle Service and/or its affiliate entities for any charges not covered by auto and health care benefits. It is my responsibility to notify Gotham Shuttle Service of any changes in my auto and health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance as determined by Gotham Shuttle Service and/or my auto and health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for transportation service received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Gotham Shuttle Service for all covered transportation service provided to me during courses of treatment and care provided by your healthcare provider. I understand and agree with this Assignment of Benefits will have continuing effect for as long as I am being transported by Gotham Shuttle Service, and will constitute a continuing authorization, maintained on file with Gotham Shuttle Service, which will authorize and allow for direct payment to Gotham Shuttle Service of all applicable and eligible insurance benefits for all subsequent and continuing transportation provided to me by Gotham Shuttle Service.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related transportation service provided to me by Gotham Shuttle Service. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Gotham Shuttle Service.

Print Name

Date

Patient/Responsible Party Signature

SSN