

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I may be entitled from an insurance plan(s) to CENTER FOR VEIN WELLNESS. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of benefits.

_____ _____

Patient's Signature/ Insured's Signature Date

MEDICARE ASSIGNMENT ***If you have Medicare, please sign the following*

I request that payment of authorized Medicare benefits may be made on my behalf to CENTER FOR VEIN WELLNESS for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on the CMS1500 or any electronically generated claim form, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient's Signature/ Insured's Signature Date

If the signature is other than the patient's, please write the patient's name followed by the signature of the person signing, and complete the following:

Name and Address of Signing Party_____

_____

Relationship to the patient _____

Reason the patient could not sign _____