South Texas ENT Consultants, PA, 7909 Fredericksburg Road, Suite 100, San Antonio, TX 78229-3403

Assignment of Benefits Form

Financial Responsibility

I have read, understand, and agree to **South Texas ENT Consultants, PA**'s Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to **South Texas ENT Consultants, PA** for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **South Texas ENT Consultants, PA** to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from **South Texas ENT Consultants, PA** on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____

Relationship to Patient

_____ _____

Witness Date

Patient Receiving Specialized ENT Services & Procedures

As a courtesy to me South Texas ENT Consultants has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that South Texas ENT Consultants has acted in good faith in this effort and that the benefit information provided to South Texas ENT Consultants by my health insurance company may not be accurate.

I acknowledge that the benefit information obtained by South Texas ENT Consultants on by behalf was qualified by a representative of my health insurance company with the following statements: 1.) This is an estimate of the benefits provided under the patient's insurance contract; 2.) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service; 3.) Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the time services are rendered.

_____ _____

Patient/Responsible Party Signature Date