

Texas Vascular Associates, P.A.

ASSIGNMENT OF BENEFITS

I hereby authorize the vascular surgeons of Texas Vascular Associates, P.A., to furnish my insurance company(s), attorney or legal representative(s) all information in which said parties may request concerning my present illness or injury.

I hereby assign the above named physicians all money/benefits to which I am entitled for medical and/or surgical expenses relative to the service reported herein, but not to exceed my indebtedness to said physician and surgeon. I appoint Texas Vascular Associates, P.A. to act as my authorized representative regarding my insurance, and I agree that if my claim is denied I request that an appeal be filed. If the payment denial is overturned on appeal, I agree that the plan's payment should be paid directly to my authorized representative and direct the plan to do so in that event.

I also agree and understand that any and all co-payment, co-insurance and deductible amounts are due at each office visit or at the time services are rendered. It is understood that any money received by the above named parties, over and above my indebtedness, will be refunded to the appropriate party when my bill is paid in full.

I consent to and authorize the physicians at Texas Vascular Associates, P.A. to treat any condition that I might have and seek treatment for.

Please be advised that certain physician owners of Texas Vascular Associates, P.A. have an indirect ownership interest in the Baylor Jack and Jane Hamilton Heart and Vascular Hospital and Texas Heart Hospital of Plano (the "Hospital"). Due to such ownership interest, your treating physician may receive, indirectly, remuneration as a result of procedures performed at the Hospital. If you do not wish to be admitted to either of these Hospitals, you may choose another hospital at which your physician is credentialed to perform professional medical services and procedures.

A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Signature: _____

Date: _____

Parent Signature: _____

Date: _____

(If patient is a minor under 18 years of age)

MEDICARE PATIENTS ONLY

Name of Patient (Beneficiary): _____

HIC Number (Medicare #): _____

I request that payment of authorized Medicare benefits be either to me or on my behalf to Texas Vascular Associates, PA for any services furnished to me by Texas Vascular Associates, PA. I authorize any holder of medical information about me to release to the centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits or the payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient (Beneficiary) Signature: _____

Date: _____