

ANESTHESIOLOGIST'S ASSIGNMENT OF BENEFITS

Your anesthesiologist, like your surgeon and other physicians at this facility, are independent private practitioners who bill separately for professional services. Your anesthesiologist is not an employee of this facility and might not participate in the same insurance plans as this facility.

I hereby assign to Dr. _____ my rights and interest in medical benefits payable to me for anesthesia professional services rendered. I acknowledge that I am responsible for paying the above referenced physician's charges in full and that I agree to forward any monies sent to me for anesthesia professional services to the above referenced physician.

I understand that I will be billed and held responsible for any co-payment, deductible, and/or coinsurance that is applicable based on the terms of my insurance benefit agreement. I acknowledge that in the event that my insurance carrier should deem the services medically unnecessary I am still responsible and agree to pay the above referenced physician's charges in full.

I authorize the above-named physician to release to my insurance carrier and its agent any information needed to determine the benefits payable under my coverage. I further authorize my insurance company and its carrier to release any information necessary for payment of charges incurred.

By signing below I agree to the terms above and request the anesthesia professional services of the above referenced physician.

PATIENT NAME (Please Print)

DATE

PATIENT SIGNATURE

YOU HAVE A RIGHT TO A COPY OF THIS FORM.