

# COASTAL VASCULAR & INTERVENTIONAL, PLLC

## ASSIGNMENT OF BENEFITS

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Patient) (Name of Insurance Carrier)

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Name of Financially Responsible Party) (Name of Insurance Carrier)

to make medical benefits payments, otherwise payable to me for services rendered by Practice and staff payable to and mailed directly to Coastal Vascular & Interventional, PLLC (Practice).

Furthermore, I hereby IRREVOCABLY ASSIGN to Practice the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges, provided by Practice.

Furthermore, the undersigned by these presents does hereby make, constitute and appoint Practice and any of its duly authorized agents and employee as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Practice's which checks, drafts or money orders are made payable for services which have been made by Practice, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Practice or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements.

## MEDICAL RELEASE

Furthermore, a photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Practice's or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

## FINANCIAL RESPONSIBILITY

Co-Pays, deductibles and fees for non covered services are due at the time of service. If after your claim has been filed with your insurance company, a patient responsibility amount is due you will receive a statement of your financial responsibility will be sent to you. Failure to pay the patient responsibility may result in your account being assigned to a collection agency. If your account is turned over to a collection agency, you will be responsible for your balance **and** the collection company's current fee. If collection efforts fail, your account may be turned over to an attorney for legal action.

## CONSENT TO TREAT

I authorize Practice to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risks involved and the possibilities of complications have been fully explained to me.

By signing below I understand and agree to the policies listed above.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
FINANCIALLY RESPONSIBLE PARTY'S SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE