Round Rock | South Austin |Central Austin | Cedar Park |Georgetown | Waco| Killeen| Amarillo
Phone: (512) 244-4272 | Fax: (512) 244-2895 | www.austinpaindoctor.com

ASSIGNMENT OF INSURANCE BENEFITS, CONSENT FOR TREATMENT, GUARANTY, AND STATEMENT OF SERVICE

Patient's Name: Date of Birth:

I hereby assign and authorize payment made directly to **Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center** of all of my covered health insurance benefits including Medicare, Medicaid, Medigap, HSA, commercial, all third party payers, or private managed care plans and insurance whether payable directly to me by any or all third party payers.

I UNDERSTAND my health insurance plan or third party payers may not cover part or all of the medical services rendered. *I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payers, including deductibles and co-insurance regardless of reason given for non-payment*. *I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payers related to care rendered by Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center and agree that failure to do so will make me responsible for the entire billed charge.* My assignment of benefits covers Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center physicians and surgical center for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits *supersedes* any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payer to pay me directly. A copy of this form shall be considered as valid as the original. I have received a copy of Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center's patient information brochure.

I UNDERSTAND Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center, is a licensed surgical center and multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the physicians at Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center provide. I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payers, including but not limited to my health insurance and/or managed care plans. I acknowledge *some or all of my care*, including surgical center facility fees, laboratory testing, x-rays, CT, DEXA, MRI, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I HAVE DISCLOSED the names of all my health insurance plans and third party payers, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center, of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so may make me fully responsible for the *entire* bill. In consideration of the services furnished to me, I hereby agree to pay any balance due *within thirty (30) days* from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that *TRAVIS COUNTY, TX* will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I UNDERSTAND it is ultimately my responsibility to obtain all required referral authorizations and/or pre-certifications for medical services that are required by my health insurance plan and/or third party payers. I acknowledge that this is *not* the responsibility of Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center.

I ALSO ACKNOWLEDGE no guarantees have been made by any employee of Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payer(s) or health insurance plans; or (3) whether any care rendered by Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans.

I AGREE to fully cooperate with Advanced Pain Care, Advanced Rheumatology Care, or Round Rock Surgery Center to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payers.

Patient Signature: Date signed: