Cosmetic Vein Centers of Texas

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance to pay the Doctor the amount(s) due on my claim for services rendered to my dependent or me. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability were such that it is not covered by the policy, I will be responsible for payment of the entire bill. Furthermore, "I request that payment of authorized Medicare benefits be made to me or on my behalf to Mark E. Skellenger, MD for any services furnished to me. I authorize any holder of medical information about to me to release the Healthcare Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services" INITIALS _____

Financial Agreement/Billing Authorization

1. All services are to be pain at the time of service. HMO, PPO and Managed Care members are billable only if we are contracted with the carrier at the time services are rendered and have a valid authorization. All diagnostic and therapeutic procedures which are classified as COSMETIC are payable at the time of service.
2. In consideration of the services to be rendered to me/patient, I hereby individually obligate myself to pay the account of Cosmetic Vein Centers of Texas in accordance with the rates and terms for the Center and Physician. Should the accounts be referred to an attorney or collection agency, I shall pay reasonable attorneys and collection expenses.
3. I certify that I am the patient am duly authorized by the patient and/or guarantor to execute this document and accept its terms.
4. If my insurance is Medicare, I certify that the information given to me is applying for payment under Title XVII of the Social Security Administration Act is correct.
5. I give Cosmetic Vein Centers of Texas the right to appeal any claims not processed correctly in my behalf. I authorize and/or aggregate to act as an agent in the billing of Medicare or any health insurance covering services rendered by the physician and/or Cosmetic Vein Centers of Texas. HIPPA acknowledgement of review of Notice of Privacy Practice: I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. INITIALS _____
6. I give permission for Dr. Mark Skellenger to communicate with my referring provider regarding my condition and medical treatment. INITIALS _____

SERVICES RENDERED ARE TO BE PAID AT TIME OF VISIT AND NON-REFUNDABLE

X_____
Patient/Guarantor Signature and Date

Print Name: _____ Relationship (if not patient): _____