Assignment of Benefits/Rights Form

Notice of Financial Responsibility:

All professional services rendered are charged to the patient and are due for payment at the time of service. **JC Anesthesia, LLC** will be glad to bill your insurance carrier/health benefit provider and the necessary forms (including this Form) will be completed to help expedite insurance/benefit payments. However, all charges for services are the patient's responsibility if not covered under an applicable insurance/health benefit plan

Patient's Assignments of Benefits and Rights and Designation of Authorized Agent under Healthcare Plan:

For medical services rendered to me by **JC Anesthesia, LLC**, I hereby assign to **JC Anesthesia, LLC** all medical and surgical benefits (including but not limited to major medical benefits) as well as **all rights to make claims, appeal claims, and/or otherwise address payment of benefits under any Health benefits/Health insurance coverage plan to which I am entitled**, including Medicare plans, private insurance plans and any other health/medical plan, to the greatest degree permitted under my plan or applicable law
To the extent a Health benefit/Health Insurance Provider/Administrator requires my specific consent for **JC Anesthesia, LLC** to act on my behalf as an authorized representative and/or agent regarding a claim and/or an appeal of a claim for payment of benefits at any level or in any form, I hereby grant **JC Anesthesia, LLC** such consent to act as my authorized representative and/or agent.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to the greatest degree permitted under my plan or applicable law, to issue payment(s) directly to **JC Anesthesia, LLC** for medical services rendered to myself and/or my dependents by **JC Anesthesia, LLC** regardless of my right under the plan to personally receive the benefits. I understand that I am responsible for any amount not covered by insurance or a health coverage plan.

A photocopy of this assignment and authorization is considered as valid as the original.

Patient's Authorization to Release Information:

I hereby authorize **JC Anesthesia, LLC** to furnish, release, and/or receive any health information concerning me, my illnesses and my treatments necessary in communication with any insurance carrier/health benefit provider to process my insurance claim acquired in the course of my examination and treatment, including any appeal process when required, and to allow a photocopy of my signature to be used to process my insurance claim for an indefinite period. This authorization will remain in effect until revoked by me in writing.

I have requested reasonable medical services from **JC Anesthesia, LLC** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered, unless other arrangements are made in advance.

Acknowledged and Agreed:

________________________________ ________________

Patient/Responsible Party Date

________________________________ ________________

Witness Date

Larkins Printing
(706) 543-9871
Form #300