LONE STAR
Cardiovascular Institute

ASSIGNMENT OF BENEFITS

Financial Responsibility

Self-Pay Patient (please initialize to verify you will not be using insurance)	Initials:
Primary Insurance Name:	ID:
Subscriber (if different from patient):	Group #:
Address:	Phone #:
Secondary Insurance Name:	ID:
Subscriber (if different from patient):	Group #:
Address:	Phone:

I understand that services rendered to me by Lone Star Cardiovascular Institute are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Lone Star Cardiovascular Institute and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY.

I may be required to pay my **estimated** deductible and co-insurance at the time of service knowing that the claim must be paid within all state or federal, prompt payment guidelines. I have chosen to assign the benefits and will provide all relevant and accurate information to facilitate payment of the claim. I authorize the provider to release any information necessary to adjudicate the claim. I authorize payment for all medical and surgical benefits to which I am entitled, through private, commercial, employer, or government health plans, including major medical benefits, be made to Lone Star Cardiovascular Institute. I authorize any holder of information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or other benefits related to these services. I appoint Lone Star Cardiovascular Institute, to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

I also understand that should my insurance company send payment to me, I will forward the payment to Lone Star Cardiovascular Institute. I agree that if I fail to send the payment and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable. I request that payment of authorized Medicare benefits made on my behalf for any services furnished to me by Lone Star Cardiovascular Institute, or on its premises, including physician services.

The above information is true to the best of my knowledge. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, regardless of payment by said insurance company. I hereby authorize Lone Star Cardiovascular Institute to release all information necessary to secure payment.

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)