FORT WORTH
BRAIN & SPINE
INSTITUTE, LLP

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ASSIGNMENT OF BENEFITS

I, the undersigned, have insurance coverage with _____ and assign directly to Fort Worth Brain & Spine Institute, L.L.P., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Fort Worth Brain & Spine Institute, L.L.P., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to or on my behalf to Fort Worth Brain & Spine Institute, L.L.P., for any services furnished me by one of their physicians. I authorize any holder of information about me to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HDFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date