

**AUTHORIZATION TO PERFORM MEDICAL SERVICES AND
ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

I authorize Texas Health Care, P.L.L.C., its affiliated physicians, nurses and staff to perform all necessary medical services in connection with my physical condition.

I hereby assign to Texas Health Care, P.L.L.C.. all of my rights and benefits under my health insurance policy/plan, including my right, if any, to recover statutory damages, punitive damages, attorney's fees, court costs and interest.

I understand that I am responsible for charges not covered or reimbursed by my insurance carrier and/or its agents. I agree, in the event of non-payment or partial payment, to pay the outstanding balance owed to Texas Health Care, P.L.L.C. Patient understands that if he/she does not pay the outstanding balance owed Texas Health Care, P.L.L.C., Texas Health Care, P.L.L.C.. has the right to file suit against the patient as well as his/her insurance provider. If Texas Health Care, P.L.L.C. is forced to file suit, it will seek recovery of the balance owed, judicial interest, court costs and attorney's fees. Patient understands that, by taking an assignment of insurance benefits, Texas Health Care, P.L.L.C. is not releasing the patient from payment for medical services and products provided by Texas Health Care, P.L.L.C.

I authorize my insurance carrier to release information regarding my coverage to Texas Health Care, P.L.L.C. ("the Clinic"). I also authorize agents of any hospital, treatment center or previous physicians to furnish the Clinic copies of my medical history, services or treatment. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purpose of internal audits, research and quality assurance reviews within the Clinic.

This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Texas Health Care, P.L.L.C.

I hereby appoint Texas Health Care, P.L.L.C.. as my attorney-in-fact (power of attorney) to:

1. Provide any information in the possession of Texas Health Care, P.L.L.C. to my insurance carrier for the purpose of obtaining insurance proceeds;
2. To sign and/or complete any forms or documents necessary to present/collect from my insurance carrier/plan; and
3. To endorse any benefit checks.

I have read the above statements and accept the terms. A duplicate of this statement is considered the same as the original.

Patient Signature

Date

Responsible Party Signature/Relationship

Date