ASSIGNMENT OF BENEFITS
AUTHORIZATION TO DISCLOSE MEDICAL CONDITION INFORMATION

I,_____ hereby authorize treatment of medical services and assign all medical and/or surgical benefits for services preformed by Cardiovascular Associates, M. Gerald Garoutte, M.D., or associates to include major medical benefits to which I am entitled, private insurance, and any other health plan to: Cardiovascular Associates, M. Gerald Garoutte, M.D., or Associates.

I also authorize Cardiovascular Associates, M. Gerald Garoutte, M.D., or Associates, to disclose information regarding my medical condition to my insurance carriers in order for all claims to be processed.

Credit Policy

The office payment policy is that payment is to be paid at the time services are rendered. If you do not have insurance, payment arrangements MUST BE MADE PRIOR TO SERVICES RENDERED. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees, court costs and collection balance. Your signature below indicates you understand that payment of your charges is ultimately your responsibility and agree to comply with its policy.

Date: _____ Signature: _____
Patient or Legal Guardian (If Minor Child)

Medicare Lifetime Signature

I request that payment of authorized Medicare banefits be made to Cardiovascular Associates, M. Gerald Garoutte, M.D., or Associates.

I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, determination of the Medicare carrier as coinsurance. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Medicare Number:_____

Date:_____ Signature: _____