ASSIGNMENT OF BENEFITS / AUTHORIZATION FORM

Anesthesia Provider: Aisthesis Partners® which includes services from any of the following medical groups: Safe Sedation, PLLC; Professional Anesthesia Consultants, PC; and, Outpatient Anesthesia Specialists, PA.

Patient's Name: _____

Assignment of Health Insurance Benefits and Financial Agreement:

I hereby authorize my Anesthesia Provider to apply for benefits on my behalf with my designated health insurance carrier ("Carrier"). I assign and authorize all payments from my Carrier to be made directly to my Anesthesia Provider.

I understand that my Anesthesia Provider is required by its contract with my Carrier to bill me co-pays, deductibles or other limits included in my policy with the Carrier. I hereby agree to make such payments directly to my Anesthesia Provider that I personally am obligated to pay beyond any Carrier payment.

If my Anesthesia Provider does not have a contract with my Carrier, I understand that I will be responsible for paying my Anesthesia Provider if my Carrier does not pay the full amount. However, I authorize my Anesthesia Provider to use its best efforts to get full payment from my Carrier by filing an appeal on my behalf or if there is a denial and/or adverse benefit determination related to anesthesia services I received.

I understand that my Anesthesia Provider estimates that I may be responsible for up to $600.00 for the anesthesia services I am scheduled to receive for my procedure if my Carrier does not pay my Anesthesia Provider.

Authorization for Release of Medical Information:

I authorize my Anesthesia Provider to release any necessary information, including a copy of this form, to my Carrier and all third party payers for the purposes of processing claims related to anesthesia services rendered. I understand and agree that third parties contracted by my Anesthesia Provider for billing and collection purposes may also have access to my information, including this form.

_____
Patient / Authorized Designee Signature

_____
Date

_____
Witness

_____
Date

Patient Label