Abdominal Specialists of South Texas, LLP

718 Elizabeth St., 3rd Floor

Corpus Christi, Texas 78404

361-884-2858

ASSIGNMENT OF BENEFITS

Patient Name: ____ **Date:** ____________________________

Insurance Name: ____

ID #: ____ **Group** __________________________

I, ___________________________ understand that services rendered to me by ABDOMINAL SPECIALISTS OF SOUTH TEXAS 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 ABDOMINAL SPECIALISTS OF SOUTH TEXAS and understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance plan.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to myself I will forward the payment to ABDOMINAL SPECIALISTS OF SOUTH TEXAS within 48 hours. I agree that if I fail to send the payment to the Provider 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.

I authorize the Provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

____ ______________________________________

SIGNATURE of Patient/Legal Representative Patient/Legal Representative PRINTED Name