I SPINE SPORTS MEDICINE/ PAIN MANAGEMENT
TWILIGHT ANESTHESIA PAIN MANAGEMENT CONSORTIUM

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to cont1nuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release Information concerning mv condition and treatment to my insurance comp-any, attorney or insurance adjuster for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interests, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for serviced rendered by the physician/facility named above within 60 days following your receipt of such bill for to the extent such bills are payable under of my/our policy for benefits, less any amount which I/ we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas insurance Code, providing attorney fees, 18% penalty, court costs and interests from judgment upon violation.

THIRD PARTV LIABILITY: If *my* injuries are the result of negligence nee from a third party, then I instruct the liability carrier to dispense a separate draft to pay in full all services rendered payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

UMITED POWER OF ATTORNEY: 1 hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable Instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. lf, during the course of care, my insurance company requires me to taken examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A PHOTOCOPY OF THIS INSTRUMENT WILL SERVE AS THE ORIGINAL.

Print Name: _____ Date: _____

Signature of Patient: _____

Witness Signature: _____ Date: _____