ASSIGNMENT OF BENEFITS- CENTER

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Palo Alto Surgery Center
695 High Street
Palo Alto, CA 94301

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, Palo Alto Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If my insurance company sends me/partner any checks for services provided at the Center, I will immediately bring or mail the check to Palo Alto Surgery Center. I will endorse the check and annotate "Pay to the Order of Palo Alto Surgery Center" or deposit the check, then send a personal or cashiers check. If it is necessary to file a formal collection action, I agree to pay all costs incurred by the outpatient center in the collection of the outstanding fees. Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based on their determination of medical necessity. The information received from the above stated is not a guarantee of payment. I agree that I am responsible for annual deductibles or services not covered by my insurance company(s), regardless of whether my insurance is Medicare, Private or HMO. Physician, Laboratory and Pathology services are billed separately from the Center. Cash patients are required to pay the Center at the time of service.

X ____

Patient Signature or Financially Responsible Party | Relationship to patient if not patient | Date

ASSIGNMENT OF BENEFITS- ANESTHESIA

For ANESTHESIA SERVICES rendered, I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

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for the anesthesia benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, my anesthesia provider will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X ____

Patient Signature or Financially Responsible Party | Relationship to patient if not patient | Date

Palo Alto Surgery Center

Patient Name:
Surgeon:
Date of Service
Medical Record:
Date of Birth
Gender: