**Potomac Anesthesiology Associates, P.A.** Patient Sticker

**Holy Cross Anesthesiology Associates, P.A.**

**Authorization and Assignments of Benefits**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, in consideration of the professional services render to me by Potomac Anesthesiology Associates and Holy Cross Anesthesiology Associates, P.A., voluntarily give my consent for such treatment and agree to the following:

**Authorization for Release of Information**

For the purpose of reimbursement of fees for the professional service rendered by Potomac Anesthesiology Associates (PAA) and Holy Cross Anesthesiology Associates (HCAA), P.A., I authorize the release of any necessary information to third party payors, insurance companies, attorneys, or other relevant parties to ensure payment for such services. Information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

**Assignment of Benefits**

For the services rendered, I hereby authorize my insurance company to assign and transfer any benefits due me to be paid directly to PAA or HCAA, P.A.. It is agreed that payment to PAA and HCAA pursuant to this authorization, by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement. If after 60 days from the date of services rendered and my insurance has not been paid, I will be responsible for all balance is due.

**Financial Understanding and Guarantee of Payment**

I understand that services rendered by PAA or HCAA, P.A. will require payment, and I acknowledge complete responsibility for such payment. I hereby obligate myself to pay the account of PAA or HCAA, P.A. in accordance with regular rates and terms of such payment, and guarantee payment within three months from the date of services rendered. I further acknowledge responsibility for payments of all deductibles, co-payments, or other fees not covered by insurers or third party payors incurred by me as a result of services rendered. Should the account be referred to an attorney or licensed collection agency for collections, I shall be responsible for payment of all reasonable attorneys’ fees and other collection expenses.

I hear by authorize any benefits due to me to be paid directly to PAA or HCAA, P.A. in accordance with this assignment. I certify that I am the patient, a duly authorized general agent of the patient, or guardian of the patient, if a minor, and am authorized to execute this document and accept its terms.

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Signature

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Witness