



**ASSIGNMENT OF BENEFITS**

**Private insurance authorization for assignment of benefits and information release**

I, the undersigned, authorize payment of medical benefits to Hill Country Pain Associates for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Hill Country Pain Associates to release to my insurance company, referring physician and other consultants on my case, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

Date \_\_\_\_\_

Signed \_\_\_\_\_

**MEDICAL LIFETIME SIGNATURE ON FILE**

I request that the payment of authorized Medicare benefits be made on my behalf to Hill Country Pain Associates for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date \_\_\_\_\_

Signed \_\_\_\_\_

**CERTIFICATION**

Hill Country Pain Associates is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation. We will be happy to assist you in this process. Also, if this is a litigation case, our office needs to be informed before services are rendered.

*I \_\_\_\_\_ hereby certify that I **am/am not** seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.*

MVA/Date of Incident \_\_\_\_\_

If applicable, Attorney's Name \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

**HEALTH INSURANCE PERTABILITY AND ACCOUNTABILITY ACT**

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy of Hill Country Pain Associates.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature