CareFIRST

ASSIGNMENT OF BENEFITS

The undersigned patient and or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to CareFirst Medical Associates, PA the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, other doctors, or insurance adjuster, for the purposes of processing my claim for benefits and payments 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 any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name, and prosecute and receive penalties, interest, court cost, 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 or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information 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 CareFirst Medical Associates, PA, you are hereby tendered demand to pay in full the bill for services rendered by CareFirst Medical Associates, PA within sixty days following your receipt of such bill for services to the extent such bills are payable under the terms 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 for attorney fees, 18% penalty, court costs, and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence for a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered payable directly to CareFirst Medical Associates, PA.

STATUTE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claim for services rendered or to be rendered by CareFirst Medical Associates, PA, In addition to reasonable costs of collection, including attorney fees and court costs, if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to CareFirst Medical Associates, PA the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment for any insurance company representing payment for treatment and health care rendered by CareFirst Medical Associates, PA. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to CareFirst Medical Associates, PA.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my doctor, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period or time. If, during the course of my care, my insurance company required me to take examination from another doctor, I will notify CareFirst Medical Associates, PA immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as the original.

_____ _____

Signature of the patient and/or responsible parties: Date