PATIENT BILLING INFORMATION

ASSIGNMENT OF BENEFITS
Anesthesia Dynamics LLC/Miami Anesthesia Services
LB# 8247 PO Box 9500
Philadelphia PA 19195-0001

Anesthesia is a commonly covered component of your surgery. As a courtesy, the bill/claim for anesthesia services will be filed directly to the primary insurance carrier. We have accepted the above assignment of benefits and your insurer should send the payment directly to our address. If we have a secondary insurer on file, we may file a claim for the amount not paid by your primary insurer. If no secondary insurance was provided, we may send you a statement for the co-pay due as determined by your insurer.

You will receive an explanation of benefits from your insurance carrier once your claim has been processed. Unless other payment arrangements have been made, please do not make any payments for anesthesia services until a billing statement is received from **Anesthesia Dynamics/Miami Anesthesia Services**. Once a billing statement is received, you will need to make the check payable to **Anesthesia Dynamics/Miami Anesthesia Servcies** and mail the check to the address above. If you have any questions or concerns, please contact our billing office at **1-888-851-4642.**

Please ask any questions that you may have so the content of this letter is understood at the time of service.

I _____ (Print Name) with insurance benefits through _____ (Employer Name if applicable) _____ (Medicare, Medicaid, Individual or Group Plan) hereby authorize benefits to be assigned to **Anesthesia Dynamics, LLC/Miami Anesthesia Servcies**. ("Provider"), for healthcare services rendered to me, or to the patient for whom I am a Guardian, if applicable, by Provider, pursuant to O.C.G.A. § 33-24-54, and all other applicable state and federal laws. I certify that the information identified herein is true and accurate as of the date of service and that I am responsible for keeping it updated. I am aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand that my insurer may not pay 100% of the medical claim, and I may be responsible for any amounts not payable by my insurer, including any portion paid and not applied to in-network benefits for any out-of-network services.

I authorize the Provider to submit claims on my behalf to the insurance company providing my benefits, under any applicable plans held in my name or for my benefit. I understand under applicable state and federal law that I have the right and authority to direct where payment for services rendered be sent. I hereby instruct and direct my Insurer to pay all plan benefits directly to Provider for all services rendered. If my current policy prohibits direct payment to the provider of service, I hereby instruct my Insurer to issue a check directly to Provider, mailed to the address listed above, or otherwise designated by Provider for payment. Said check shall be made payable to me as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse "for deposit only," and to deposit and apply all proceeds toward payment of my account. This authorization includes any and all rights permissible, including all rights of appeal, disclosures, administrative reviews, litigation on my behalf and remedies due under any applicable state or federal law, or plan language provision.

I authorize the release of any information pertinent to my case to any insurer, adjuster, government agency or attorney as may be required to enforce my rights and the rights of Provider hereunder. A copy of this Assignment shall be treated as an original. I have read and understand the foregoing, and hereby authorize Provider to provide medical care that is reasonable and at the standard of care as required by state law, and as set forth herein.

Patient Name:	Patient Signature:
Policy Holder Name: (if different from patient)	Parent/Guardian Signature (if applicable):
Insurance Company: Policy Number:	Date:
	Email address: