GENERAL SURGICAL Associates

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to General Surgical Associates of San Antonio 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 General Surgical Associates of San Antonio 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 evaluating and administering claims of benefits.

Date _____ Signed _____

CERTIFICATION

General Surgical Associates of San Antonio is pleased to offer you treatment. 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.

*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 _____

Print Patient Name _____Date _____

Patient Signature _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of General Surgical Associates of San Antonio. I authorize release of my medical information to the following:

☐ Spouse: _____

☐ Family Member: _____

☐ Other:_____ Relationship: _____

Print Patient Name _____Date _____

Patient Signature _____