Providing Professional Anesthesia Services for patients of
"AT YOUR SERVICE ANESTHESIA, LLC"

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to AT YOUR SERVICE ANESTHESIA, LLC , (Practice), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between the Practice and my insurance company). I authorize and direct the insurance company to pay all such benefits to the Practice. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and the Practice.

Authorization to Release Claims Information: I hereby authorize the Practice, it employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the propose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize the Practice, its employees and agents to act on my behalf in completing claims.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that the Practice is willing to provide Professional anesthesia services as requested by my attending Physician I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary Personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

_____ _____

Print Name of Patient/Authorized Guardian Date of Service

_____ _____

Signature of Patient/Authorized Guardian Signature Date

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

ANESTHESIA SERVICES ARE PROVIDED AT _____ BY PRACTICE, AND ITS EMPLOYEES ARE INDEPENDENT HEALTH PROVIDERS AND ARE NOT EMPLOYEES OR AGENTS OF " _____ " . PRACTICE EMPLOYS AND UTILIZES CERTIFIED REGISTERED NURSE ANESTHETISTS AND PHYSICIAN ASSISTANT ANESTHESIOLOGY ASSISTANTS AS PART OF THE ANESTHESIA CARE TEAM.

ANESTHESIA SERVICES WILL BILLED SEPARATELY FROM THE SERVICES OF " _____ _____" FOR AN ESTIMATE OF ANESTHESIA CHARGES, OR OTHER BILLING QUESTIONS, CALL _____.