ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Vantage Health, LLC and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Vantage Health, LLC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Vantage Health, LLC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Vantage Health, LLC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Vantage Health, LLC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Vantage Health, LLC, and will constitute a continuing authorization, maintained on file with Vantage Health, LLC, which will authorize and allow for direct payment to Vantage Health, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Vantage Health, LLC.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Vantage Health, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity if requested. The original authorization will be kept on file by Vantage Health, LLC.

X _____ _____

Patient/Legal Guardian/Authorized Person (Signature) | Date of Signature

_____ _____

Patient/Legal Guardian/Authorized Person (Printed Name) | Relationship If Other Than Patient

X _____ _____

Witness (Signature) | Date of Signature