



ASSIGNMENT OF BENEFITS

- **ASSIGNMENT OF MEDICAL BENEFITS**

I hereby assign and transfer to Northwest Vein and Aesthetic Center, all of my rights, title and interest to any medical reimbursement benefits under my insurance policy or Worker's Compensation carrier for services provided by them.

- **MEDICARE ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medicare benefits be made to Northwest Vein and Aesthetics Center for services provided by a physician or supplier.

I authorize the release of medical information to the Center for Medicare and Medicaid Service (CMS) for the determination of benefits.

I understand I am personally responsible for any balance not covered by my insurance carrier.

Signature: _____ **Date:** _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE