



ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release

I, _____ the undersigned, authorize payment of medical benefits to VAYU Advanced Wound Clinic & Hyperbarics 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 VAYU Advanced Wound Clinic & Hyperbarics 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: _____ Signature: _____

CERTIFICATION

VAYU Advance Wound Clinic & Hyperbarics 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

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of VAYU Advanced Wound Clinic & Hyperbarics.

Signature: _____

Printed Name: _____ Date: _____