Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Bridlewood Family Healthcare for medical services rendered to my-self and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Bridlewood Family Healthcare to: (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Bridlewood Family Healthcare on behalf of my-self and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

Bridlewood Family Healthcare, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

Our Practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____

Print Patient Name Signature of Patient

_____

Signature of Patient/Guardian if Minor Relationship of Patient

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Notice of Financial Interest

I have been informed that my physician ***Dr. Brian D. Glaser*** has a financial interest in the following healthcare facilities:

Texas Health Presbyterian Hospital Flower Mound
Flower Mound, TX 75028
(469) 322-7000

I understand that my Physician may refer me to the facility listed above or any other healthcare facility of my choice.

I acknowledge that I have read this Notice of Financial Interest and have been able to ask questions and receive answers regarding it.

_____

Patient (Guardian) Signature

Bridlewood Family Healthcare, P.A.
Brian D. Glaser, DO

_____

Date