1217 S. East Ave. Suite 104
Sarasota, FL 34239
941-365-0433 941-954-2064 (FAX)

ASSIGNMENT OF INSURANCE BENEFITS
MEDICARE AND SUPPLEMENTAL INSURANCE

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to Heart & Vascular Center of Sarasota on my behalf.

I authorize Heart & Vascular Center of Sarasota to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, Heart & Vascular Center of Sarasota may prescribe testing procedures to be performed here. I understand the Heart & Vascular Center of Sarasota is the owner, and I have been advised that according to Florida Law I am under no obligation to use this facility.

I understand that I am responsible for payment of any non-covered service, deductible, and/or co-payment due.

Signature _____ Date_____

COMMERCIAL INSURANCE

I request that payment of authorized benefits be made on my behalf to Heart & Vascular Center of Sarasota for any services provided by Heart & Vascular Center of Sarasota physicians. I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. *I understand that I am responsible for payment of any charges in full, including non-covered services, deductible and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. Heart & Vascular Center of Sarasota will request a pre-authorization from your insurance company on procedures ordered by Heart & Vascular Center of Sarasota. It is your responsibility to ensure that an authorization is on file with Heart & Vascular Center of Sarasota prior to having your procedure performed. When applicable, I understand that I am responsible for payment of all charges in full due to no authorization.*

Signature _____ Date_____