ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE & OTHER PRIVATE INSURANCE OR HMO COVERAGE TO:

BUCKS COUNTY CENTER FOR VEIN MEDICINE
DR MICHAEL C JACOBELLI, M.D.,F.A.C.S.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOLKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AND AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES OF SERVICES, WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ALL COPAYS DUE FOR SERVICES PROVIDED OR IF MY DEDUCTIBLE HAS NOT YET BEEN MET OR IF THERE IS A CO-INSURANCE DUE. I AM ALSO RESPONSIBLE FOR ANY SERVICE THAT MY INSURANCE DOES NOT MAKE PAYMENT FOR "NON-COVERED SERVICE'. I WILL ALSO BE RESPONSIBLE FOR ANY CHARGE OR SERVICE INCURRED IF SERVICE WAS PROVIDED WHEN MY ENROLLMENT IN SAID INSURANCE WAS NOT IN EFFECT, CANCELLED OR IF I DO NOT HAVE HEALTH INSURANCE.

I ALSO HEREBY AUTHORIZE THE BUCKS COUNTY CENTER FOR VEIN MEDICINE TO RELEASE MY MEDICAL HISTORY, OR COPIES THEREOF, ANY INFORMATION NECESSARY FOR MY CARE BY A MEDICAL SPECIALIST OR CONSULTANT.

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SIGNATURE DATE