EVOLVE Wellness & Aesthetics

Medicare Assignment of Benefits

Medicare Assignment of Benefits to Statement to Permit of Heath and/or Medical Insurance Benefits to Evolve Wellness and Aesthetics and Providers

I certify that the information given by me in applying for payment under title XVLlll of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician and / or mid-level (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and coinsurance.

FINANCIAL RESPONSIBILITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, if I am unable to pay in full at the time service is rendered; Pioneer Healthcare Clinic may inquire of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5%)per month/ 18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to as an attorney or collection agency for collection suits, I agree to pay all reasonable attorney fees and/ or collection expenses.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Evolve Wellness and Aesthetics any benefits under hospitalization, sickness liability, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate, aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

AUTHORIZATION FOR CARE

I hereby authorize the staff of Evolve Wellness and Aesthetics to administer such care/ treatment as it is necessary based on the clinical provider's assessment and diagnosis. I understand that such care may include medical and surgical treatment, laboratory, and radiologic tests. I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize staff of Evolve Wellness and Aesthetics to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein: to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer (or their agent/s) for the purpose of obtaining payment to employees, offices and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV and other diseases, all of which I specifically authorize to be so released.

Relationship to Patient: _____

_____ _____

Patient or Representative Signature Date