Assignment of Benefits Form

I, ____, understand that services rendered to me by O'Donnell Vein and Laser/Kelly O'Donnell, M.D. are my financial responsibility, and that the provider will bill my insurance company. I authorize my insurance company to pay my benefits directly to the O'Donnell Vein and Laser/Kelly O'Donnell, M.D. and I understand that I will be responsible for any amount allowed and not paid by my insurance company. I am also responsible for any deductible, copay and/or co-insurance.

I authorize the provider to release any information necessary to adjudicate my claims.

I also understand that should my insurance company send payment directly to me, I will forward the payment to the office in a timely manner.

I certify that the information I have provided with regard to my insurance coverage is current and correct. I agree to continually provide current and accurate health insurance information should any changes occur. I agree to notify the office of any updated insurance information prior to any services being rendered.

I authorize O'Donnell Vein and Laser/Kelly O'Donnell, M.D. to initiate a compliant or file an appeal to my insurance company and/or the insurance commissioner on my behalf and I personally will be active in the resolution of any claim delays, unjustified reductions or denials.

Patient Signature: ____ Date: _________________

Parent or Guardian Signature: ________________________________ Date: _________________

Collection Agreement

If payment is not made as agreed, I will be responsible for all court costs, 35% collection fees and attorney fees.

Patient Signature: ____ Date: _________________

Parent or Guardian Signature: ________________________________ Date: _________________