

RENAISSANCE

PLASTIC SURGERY, P.C. SURGICAL CENTRE', LLC

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED TO OUR PRACTICE. PLEASE PUT AN X IN THE SPACE PROVIDED THAT BEST DESCRIBES YOUR STATUS IN REGARDS TO YOUR INSURANCE COVERAGE.

_____ *The Non-Medicare Patient*

I hereby assign to Renaissance Plastic Surgery and Renaissance Surgical Centre' any and all benefits from my insurance plan/plans and authorize and direct such benefits to be paid directly to Renaissance Plastic Surgery and Renaissance Surgical Centre. I certify that the information given by me in applying for payment under my insurance plan is correct and complete. I authorize release of all records required to act on this release and assignment.

_____ *The Medicare Patient*

I request that payment of authorized Medicare benefits be made on my behalf to Renaissance Plastic Surgery and Renaissance Surgical Centre' for any services rendered. 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 certify that the information given by me in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read the information above and all my questions have been answered by the staff at Renaissance Plastic Surgery and Renaissance Surgical Centre.

Patient: _____

Signature: _____

Witness: _____

Date: _____