PATIENT BILLING INFORMATION

Anesthesia is commonly a covered component of your surgery. As a courtesy, the bill/claim for anesthesia services will be filed directly to the primary insurer. We will accepted the assignment of benefits (below) and your insurer should send the payment directly to our address. If we have a secondary insurer on file, we may file a claim for the amount not paid by your primary insurer. If no secondary insurance was provided, we may send you a statement for the co-pay due as determined by your insurer.

In the event that Sarasota Anesthesiologists, PA. is not a participating provider with your plan, we will work directly with your insurer(s). The amount you may owe will be within the applicable "Reasonable and Customary" benefit rate limits. We often negotiate with insurers to minimize out-of-pocket costs due to our out-of-network status. In the event that your balance due for services differs from your explanation of benefits ("EOB") based on an adjustment by us, please contact your insurer(s) to alert them of the adjustment. It is your responsibility to contact the insurer(s) to report any adjustments applied to the patient portion due. This allows them to update their records to reflect any differences in your out-of-network deductible, out-of-pocket expenses and catastrophic cap for the benefit year.

If your insurance carrier sends payment directly to you, please contact us immediately so we may notate your account to avoid any unnecessary requests for payment. Once you reach us, we will ask that you deposit the check into your account and write a personal check for the amount of the payment you received. You will need to make the check out to Sarasota Anesthesiologists, PA and mail the check to the address above. We will also require a copy of the original EOB you received when mailing. If you have any questions or concerns, please contact our billing company at **1-941-366-2360**. You may also contact our Administrative Office at **1-941-366-2360.** Please ask any questions that you may have so the content of this letter is understood at the time of service.

ASSIGNMENT OF BENEFITS

Sarasota Anesthesiologists, PA
1261 South Tamiami Trail
Sarasota, FL 34239

I _____ (Print Name) hereby authorize benefits to be assigned to Sarasota Anesthesiologists, PA, ("Provider"), for healthcare services rendered to me, or to the patient for whom I am a Guardian, if applicable, by Provider, pursuant to Florida Section 627 and all other applicable state and federal laws. I certify that the information identified herein is true and accurate as of the date of service and that I am responsible for keeping it updated. I am aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand that my insurer may not pay 100% of the medical claim, and I may be responsible for any amounts not payable by my insurer, including any portion paid and not applied to in-network benefits for any out-of-network services.

I authorize Provider to submit claims on my behalf to the insurance company providing my benefits, under any applicable plans held in my name or for my benefit. I hereby instruct and direct my Insurer to pay all plan benefits directly to Provider for all services rendered. I understand under applicable state and federal law that I have the right and authority to direct where payment for services rendered be sent. If my current policy prohibits direct payment to the provider of service, I hereby instruct my Insurer to issue a check directly to Provider, mailed to the address listed above, or otherwise designated by Provider for payment. Said check shall be made payable to me as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse "for deposit only," and to deposit and apply all proceeds toward payment of my account. This authorization includes any and all rights permissible, including all rights of appeal, disclosures, administrative reviews, litigation on my behalf and remedies due under any applicable state or federal law, or plan language provision.

I authorize the release of any information pertinent to my case to any insurer, adjuster, government agency or attorney as may be required to enforce my rights and the rights of Provider hereunder. A copy of this Assignment shall be treated as an original. I have read and understand the foregoing, and hereby authorize Provider to provide medical care that is reasonable and at the standard of care as required by state law, and as set forth herein.

Patient Name:	Patient Signature:
Policy Holder Name: (if different from patient)	Parent/Guardian Signature (if applicable):
Insurance Company: Policy Number:	Date: