Rio Grande PAIN Team
Get out of Pain... Get on with Life

DENNIS SLAVIN, M.D.

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:
I, the undersigned, authorize payment of medical benefits to Rio Grande Pain Team for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Rio Grande Pain Team to release to my insurance company, referring physician and other consultants on my case information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date ________________ Signed ______________________________________

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Rio Grande Pain Team for any services furnished to me by the physician. 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 these benefits payable for related services.

Date ________________Signed ______________________________________

CERTIFICATION

Rio Grande Pain Team is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation.

I ______________hereby certify that I ***am/am not*** *seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.*

MVA / Date of Incident ______________________________________

Print Patient Name ______________________________Date ________________

Patient Signature ______________________________

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Rio Grande Pain Team.

Print Patient Name ______________________________Date ________________

Patient Signature ______________________________

WESLACO: 910 East Eight Street, Suite 1 • Weslaco, Texas 78596 • 956-973-0565 • Fax: 956-973-0683
MCALLEN: 1900 South Jackson Road • McAllen, Texas 78503 • 956-992-0319 • Fax: 956-973-0683