The C.S.I.
The Center For Surgical Intervention

Patient Name: _____ **Date of Birth:** _____

I, the undersigned, have been informed that in the event the insurance company sends the reimbursement check to me, the insured, I am responsible for signing said check over to The Center for Surgical Intervention. I am aware that checks sent to me are the intended property of The Center for Surgical Intervention. I am also fully responsible for the delivery of said check and corresponding EOB to The Center for Surgical Intervention to 9811 W Charleston Blvd Ste 2-389, Las Vegas, NV 89117 by mail, or 5950 S Durango Dr Ste 101, Las Vegas, NV 89113 in person.

If I should fail to deliver said check in full within 10 days of receipt, I understand that I will be responsible for all billed charges. Also any agreement; verbal or otherwise, is null and void and any cash discounts I may have received as a courtesy, will be reversed and applied to my account. I also understand failure to deliver these checks and corresponding EOBs will result on my account being sent to collections with a 35% collection fee added. I also have been advised that the collections process will begin with litigation and all other courtesies will be bypassed.

Initial_____ Assignment of Benefits I authorize The Center for Surgical Intervention to endorse and deposit checks received for payment of my health care benefits in the event they are made out to me. I hereby instruct and direct my Insurance Company to pay by check made out to **and** mailed to the following address; or if my current policy prohibits direct payment to the doctor or facility, I hereby also instruct and direct you to make out the check to me and mail it as follows:

The Center for Surgical Intervention
9811 W Charleston Blvd Ste 2-389, Las Vegas, NV 89117

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. This assignment will remain effective until written notice of cancellation. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize The Center for Surgical Intervention.

Patient Signature	**Date**	**Witness Signature**	**Date**
Print Name	**Date**	**Print Name**	**Date**