Life Savers EMERGENCY ROOM
Always Open . Always Ready

17685 TOMBALL PARKWAY
HOUSTON, TX 77064
PHN: 832-779-5433 FAX: 832-604-5433

3820 NORTH SHEPHERD DR. SUITE A.
HOUSTON, TX 77018
PHN: 281-766-8911 FAX: 832-742-9896

Patient Label

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Life Savers Emergency Room, the following rights, now power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, medical care Support Company or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive irrevocable right to receive payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court cost, and interest from judgement, upon violation. I further instruct the provider to make all checks payable to Life Savers Emergency Room, and send all checks to Life Savers Emergency Room .

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to Life Savers Emergency Room, and to send any and all checks to Life Savers Emergency Room.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM claim in my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to Life Savers Emergency Room.

_____ _____

Patient Signature Date

If the consenting party is other than the patient:

I am the Qualified Personal Representative (QPR) or Legal guardian of : _____
and sign on his/her behalf. Patient Name

_____ _____

Signature of Qualified Personal Representative Printed Name of Qualified Personal Representative

_____

Legal Authority to Act on Behalf of the Patient
(Relationship to patient)