Patient: Last:_____ First:_____ Middle_____

Assignment of Benefits: I hereby assign, transfer, and set over to Trade Winds all of my rights, title, and interest to my medical reimbursement benefits under my insurance policies. To make check payable or direct deposit to Trade Winds, 2106 S. Market St., Brenham, TX 77833. If my current policy prohibits direct payment to Trade Winds, I hereby assign my insurance to make the check payable to me (the patient) and mail it to Trade Winds at the above-mentioned address. I will then assign over payment of these funds to Trade Winds to assist in the settlement of my account. I understand it is a crime to provide false information in order to receive payment from any insurance company. I will notify you of any changes in my insurance information.

Initial _____

Payment Agreement: My estimated payment of $____ is due at each visit. I understand that this estimated payment has been established to go towards my deductible/out of pocket of $___. Once my deductible has been met, my insurance pays at _____ at the end of my therapy. I understand that I am responsible for all charges until my deductible has been met at which time I will be responsible for 100% of the charges.

Initial _____

I understand that the above benefits are based on information provided by my insurance carrier. Trade Winds cannot guarantee that my claims will be processed as stated above. It is my responsibility to review my explanation of benefits when received and call my insurance carrier if I feel there are any errors. My final balance will be determined when claims are processed.

I understand that with Worker's Compensation, Trade Winds, no any institution, is able to pursue the individual for the remaining balance on the account. However, if false information is intentionally provided, the patient may be liable for any/all changes on this account.

Initial _____

Release of Information: I authorize the release of any requested records for review, by authorized representatives of Medicare, my insurance company, and my physician or provider. I authorize the review of these records for any audits within the agency. This information shall also serve as release from any legal liability that may rise from the release of these records. I authorize the release of any necessary information from my provider, if requested and related to my treatment at Trade Winds.

Initial_____

Consent to Treat: I hereby authorize the staff of Trade Winds to administer, perform and carry out all procedures as prescribed by my provider. I will notify you of any changes in my health status.

Initial _____

I have read and understand the above statements.

_____	_____	_____
Patient or Responsible Party Signature	**Witness**	**Date**

Revised 5/2017