
THOMAS A. GRUGLE, M.D., P.A.

Psychiatry
275 W. Campbell Road
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(972) 671-3100

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*Diplomate, American Board of Psychiatry and Neurology
Clinical Assistant Professor of Psychiatry
Southwestern Medical School*

Irrevocable Assignments and Financial Responsibility

In consideration of the services rendered or to be rendered. I hereby irrevocably assign and transfer to Thomas A. Grugle, M.D., P.A. (hereinafter referred to as "Physician") all right, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person or entity from whom my dependents or I am entitled to recover (hereinafter referred to as "Benefits"). I further hereby irrevocably assign and transfer to Physician all right, title, and interest in any and all causes of action against all insurance companies, employee benefit plans, third party administrators, and/or other persons or entities responsible for payment or Benefits (hereinafter referred to as "Responsible Parties"), and I hereby appoint the Physician as my attorney in fact, with power of substitution, to sue or otherwise obtain payment of Benefits from the Responsible Parties. Said irrevocable assignment and transfer shall be for the purposes of granting the Physician an independent right of recovery against such Responsible Parties, but shall not be construed to be an obligation of the Physician to pursue any such right of recovery.

I hereby authorize all Responsible Parties to pay directly to the Physician all benefits and amounts due for services rendered by the Physician.

I understand that if the Physician is not paid in full by proceeds of any Benefits, then this assignment does not release my obligation and liability to the Physician to payment for all services and items provided to me or the above-referenced Patient by the Physician. In the event no Benefits are paid by the Responsible Parties, then I agree to pay Physician for all charges incurred. In the event Benefits are paid by the Responsible Parties then I agree to pay Physician for all charges in excess of the Benefits paid. All payments will be made to Physician at 275 W. Campbell Road; Suite 121; Richardson, TX 75080.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding, and I have signed this document freely and without inducement other than the rendition of services by the Physician.

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

I hereby authorize Thomas A. Grugle, M.D., or any hospital, physician or other provider, to release any medical or incidental information that may be necessary, for either medical care or in processing applications for financial benefit, to my insurance company or lawful representative thereof. A photocopy of these assignments shall be as valid as the original.

signature of insured

date

*signature of patient
or patient's authorized
representative*

witness

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Physician Notice

Medicare or other insurance will only pay for services that it determines to be “reasonable and necessary” under section 1862(a)(1) of the Medicare law. If your insurance company determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under your insurance program standards, your insurance company will deny payment for that service. I believe that, in your case, your insurance company is likely to deny payment for:

- telephone consultations
- after hours services
- evaluation of medical records
- medical testimony
- preparation of reports and letters
- evaluation of laboratory reports
- meetings with family members or other individuals to discuss your treatment

for the following reasons:

Medicare or other insurance usually does not pay for these services for which the doctor usually charges a fee

Beneficiary Agreement

I have been notified by my physician that he believes that, in my case, Medicare or other insurance is likely to deny payment for the services identified above, for the reasons stated. If Medicare or other insurance denies payment, I agree to be personally and fully responsible for payment.

SIGNATURE OF PATIENT _____ DATE _____

MEDICARE/MEDICAID CERTIFICATIONS

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

SIGNATURE OF PATIENT _____ DATE _____