



Patient Information Form
Assignment of Benefits

Patient

SS#

I hereby instruct and direct _____ Insurance company to pay by check made out and mailed to:

**Dr. Clint A Hayes, M.D.
1701 Highway 75 North
Sherman, Texas 75090**

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the insurance company to make out the check to me and mail it as follows:

**c/o Clint A Hayes, M.D.
1701 Highway 75 North
Sherman, Texas 75090**

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. 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 this insurance payment. This payment will remain in effect until revoked by me in writing.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor, State or Federal entity, or attorney involved in this case. I acknowledge that my medical records maybe transmitted by facsimile to other Healthcare Providers, Insurance Carriers, or Government entities, involved in my medical care.

Signature _____

Date _____

Notice Concerning Complaints

Complaints about physician, as well as other licensees & registrants of the Texas State Board of Medical Examiners, including physicians assistant and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
PO Box 2018, MC-263
Austin, Texas 78768-2018