ALLEGHENY PAIN MANAGEMENT
ALLEGHENY SURGERY CENTER

ASSIGNMENT OF BENEFITS

Print Name of Patient _____

Please read and sign:

1. I acknowledge and agree that I am individually responsible for all payment of medical services rendered by Allegheny Pain Management, PC/Allegheny Surgery Center, LLC and I agree to pay all amounts due within 30 days from the billing date.
2. I request that Allegheny Pain Management, PC/Allegheny Surgery Center, LLC submit their billing directly to my insurance company and I authorize payment of medical benefits to Allegheny Pain Management, PC/Allegheny Surgery Center, LLC.
3. I irrevocably assign to Allegheny Pain Management, PC/Allegheny Surgery Center, LLC to the extent of its outstanding bill, the proceeds of any recovery which my attorney or I may obtain as a result of the accident or incident for which I am treated.

_____ _____ _____

Signature of Patient/Patient Representative/Surrogate Date Time

ADVANCE DIRECTIVE NOTIFICATION

Please read and sign:

1. In the event that I suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent implies my consent for resuscitation and transfer to a higher level of care.
2. If I so choose, I can provide Allegheny Surgery Center with a copy of my signed advance directives. This documentation will be retained in my chart. These advanced directives will be forwarded to the acute care facility in the event that transfer is deemed necessary.
3. If I do not have advanced directives and wish to have information regarding advance directives, the facility will provide the "Understanding Advanced Directives for Health Care, Living Wills and Power of Attorney in Pennsylvania." This brochure includes the appropriate form to execute an advanced directive.

_____ _____ _____

Signature of Patient/Patient Representative/Surrogate Date Time