ASSIGNMENT OF INSURANCE BENEFITS

Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Coastal Medical, Inc. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY MY BENEFIT PLAN.

______________________________ Signature

______________________ Date

Have you designated anyone to function as your legal guardian or decision marker (by completing a "living will" or "power of attorney" form) in the event that you are unable to make decisions regarding your health care? ______

If "YES," please write the name, address, phone number, and relationship of that individual:

Name: ____

Address: ____

Relationship to you: __________________ Phone: ____________

If "NO," please ask your physician about this.

I have reviewed the information in this questionnaire and verified that the information is accurate.

___________________________ Patient's signature

If questionnaire was completed by someone other than the patient:

Relationship to patient: _______________

___________________________ Patient's signature

PHYSICIAN'S NOTES: