Benton Pediatrics, Inc.

Board Certified Pediatrics
5612 N.W. 43rd Street • Gainesville, FL 32653-3332 • (352) 376-4542

Insurance Assignments and Authorization To Release Information

Patient Name ________________________________ Date of Birth __________________

I. Release Of Information: I, the below named patient (or legal representative), do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. Physician Insurance Assignment: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

III. Medicare/Medicaid: Patient's (or legal representative's), certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I permit a copy of this authorization and assignments to be used in place of the original which is on file at the physician's office.

I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy.

Today's Date __________________________ Subscriber____________________________

Responsible Party ____________________________ ____________________________

Printed Name Signature

Original signature on file at physician's office