



Benton Pediatrics, Inc.

Board Certified Pediatrics

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

Insurance Reimbursement

Patient Name _____ Date of Birth _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment, some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

In order to control billing costs, we request that charges for service be paid at the conclusion of each visit.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and Medicaid, private insurance, and other health plans to Benton Pediatrics, Inc.

This assignment will remain in effect until revoked by me in writing. a photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment.

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