Assignment of Benefits Agreement

Our office will accept an Assignment of Benefits from your company with the understanding that the contract regarding your medical benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following identifies our policies governing insurance claims.

- We require you to pay your Copay, Co-Insurance and deductible, which is the amount not covered by your insurance company at the time services are rendered.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied then you will be responsible for paying the full amount at that time.
- Completing insurance forms is a courtesy we extend to you in the effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Park Avenue Medical/Winter Park Family Health Center Inc., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Date: ____________________

Patient Name (Print): ____

Signature/Parent or Guardian: ____

Relationship to Insured: ____