☐ NP/Newborn ☐ Guarantor Change ☐ Update

REGIONAL PEDIATRIC ASSOCIATES, P.A.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

(Form to be completed by patient, parent or legal guardian)

Patient's Legal Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ **Sex:** _____ **Child's Soc. Sec. Number** _____

Address: _____
STREET / POST OFFICE BOX / APARTMENT NUMBER

_____
CITY STATE ZIP CODE

Home Phone: (_____) _____ **Chart No.** _____

Father's/Guardian's Full Name: _____ **Soc. Sec. No.:** _____ **DOB:** _____

Address (If Different From Above) _____

Father's/Guardian's Employer: _____ **Alternate Telephone No.:** _____

Mother's/Guardian's Full Name: _____ **Soc. Sec. No.:** _____ **DOB:** _____

Address (If Different From Above) _____

Mother's/Guardian's Employer: _____ **Alternate Telephone No.:** _____

Primary Insurance: _____ **Telephone:** _____

Subscriber Name: _____ **D.O.B.** _____ **Group #** _____ **Policy #** _____

Secondary Insurance: _____ **Telephone:** _____

Subscriber Name: _____ **D.O.B.** _____ **Group #** _____ **Policy #** _____

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1. **I understand any copays, co-insurance and deductibles are due at the time of service. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).**
2. **I authorize my insurance carrier to release information regarding my coverage to Regional Pediatric Associates, P. A.. I also authorize agents of any hospital, treatment center or previous physicians to furnish Regional Pediatrics Associates, P.A. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Regional Pediatric Associates, P.A..**
3. **My right to payment for all pharmaceuticals, procedures, test, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Regional Pediatrics Associates, P.A.. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Regional Pediatrics Associates, P. A..**
4. **I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) governmental bodies (such as the Food and Drug Administration and the Health Care Financing Administration); (c) representatives and agents of my health benefit plan; (d) persons conducting quality or peer review or patient satisfaction surveys; and (c) other clinical and non-clinical parties that have a contractual relationship with Regional Pediatrics Associates, P.A..**

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____

Responsible Party Signature **Relationship** **Date**

Rev. 04/07