Jacksonville Pediatrics
2606 Park Street
Jacksonville, FL 32204
904-388-4646 fax 904-388-9017

Authorization and Assignment of Benefits

For the services rendered and those about to be rendered, I hereby assign to Jacksonville Pediatrics ALL MEDICAL BENEFITS otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the current mentioned insurance company **to pay said benefits directed to Jacksonville Pediatrics**, and further direct that they make NO PAYMENT to ME. In the event that I receive payment from the insurance company, I agree to endorse such payment to JACKSONVILLE PEDIATRICS. I understand that I am directly and primarily responsible to Jacksonville Pediatrics for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or delay **[more than 30 thirty days]** in their payment, it is my sole responsibility to promptly pay my bill directly. I also realize that any service not covered under my insurance company will be my responsibility to pay in full. I further understand and agree, if I fail to make prompt and timely payment to Jacksonville Pediatrics, I will be directly responsible for any additional collection cost.

I hereby authorize Jacksonville Pediatrics to release to my insurance company, any information acquired including the Diagnosis and the records in the course of my treatment.

I hereby authorize Jacksonville Pediatrics to release any information regarding the patient such as demographic information, insurance information etc. in connection with any referral necessary in the treatment of the patient.

I consider this authorization to be valid until further notice is given to writing.

Patients Name _____

Signature
_____Relationship_____
DATE: _____