Patient's Name_____ Date of Birth_____

ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Appleseed Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Appleseed Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Appleseed Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Appleseed Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature _____ Date ___/___/_____

Name _____

Relationship to patient _____