3175 Citrus Tower Blvd Clermont, FL 34711 PH: (352) 240-3812 | FAX: (888) 716-2003
131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

ASSIGNMENT OF BENEFITS

Financial Responsibilities

I have read, understand, and agree to Advanced Kidney Care of Central FL (AKCCF), PA's Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Private Insurance, and any other health/medical plan, to issue payment check(s) to AKCCF for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize AKCCF to: (1) Release any information necessary to insurance carriers regarding my illness and treatments; (2) To process insurance claims generated in the course of examination or treatment; and (3) To 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 AKCCF on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

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

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Patient Name

______________________________	________________
Patient or Responsible Party Signature	Date
______________________________	________________
Person Signing on Behalf of Patient (Print)	Relationship to Patient
______________________________	________________
Witness Signature	Date