FASTMD
Florida Advanced Spine and Sports Trauma Centers

Pt #_____

DOB#_____

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED

Benefit Assignment/Release of Information/Financial Policy

I hereby assign all medical and/or surgical benefits, including major health benefits, Medicare, private insurance, and any other health plans or insurance including any insurance authorized by Florida Statutes, including provisions set forth under Fla. Stat. 627.736. Pursuant to this assignment, I hereby assign my insurance benefits and any and all legal and/or equitable causes of action available to me under Florida Law, (and if applicable, Federal Law), and/or my applicable health and/or automobile insurance policy to Spine and Orthopedic Specialists, LLC, the ASSIGNEE herein. I further assign to ASSIGNEE any and all derivative causes of action which may also include attorney fees and costs, extra-contractual or bad faith actions arising out of a dispute for benefits under my health and/or automobile insurance, to the ASSIGNEE. Both the ASSIGNEE and I, the undersigned patient, acknowledge that I am foregoing, and the ASSIGNEE is assuming all of these rights as they relate to the medical services rendered to me by ASSIGNEE under this agreement and thus serves as additional consideration for this assignment of benefits to the ASSIGNEE. In the event my automobile insurance company is obligated to make payments for charges made by ASSIGNEE for services rendered to me and my insurance company refuses to make or reduces such payments, I hereby request and direct the insurance company to comply with §627.736(6)(f) and provide ASSIGNEE notice that the policy limits under this section have been reached within 15 days after the limits have been reached and to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum. I also acknowledge and affirm that automobile insurance proceeds will be payable and due in Hillsborough County, Florida and that Hillsborough County, Florida will be the most convenient venue for litigation in the event that ASSIGNEE must pursue litigation against an insurer for payment of benefits for services rendered to me. Additionally, I agree that any payments made by my insurance carriers directly to me, my guarantor or my dependants, for services rendered by ASSIGNEE and its physicians and healthcare providers is the property of ASSIGNEE and will be promptly remitted to ASSIGNEE within 30 days of my receipt of such payment. I agree that benefits assigned to ASSIGNEE are for actual services rendered to me by ASSIGNEE. Additionally, I have the right to confirm that those services were performed. I acknowledge that I was not solicited by any person to seek any services from ASSIGNEE. ASSIGNEE bills my insurance carrier as a courtesy to me, although I am responsible for the entire bill when services are rendered. ASSIGNEE requires that arrangements for payment of my estimated portion of the bill be made at the time services are rendered (this estimate is not intended to release me from obligations to remit full payment open on my account balance). If my insurance carrier does not remit payment within 60 days, the balance will be due in full. The only exceptions to these terms are if I am covered by a Letter of Protection with ASSIGNEE. Additionally, an exception is made if I am a patient covered under the Florida Workers Compensation Act. I also agree to promptly remit payment of any co-payments, co-insurance and deductibles as described by my insurance carrier at the time services are rendered. In any event, I agree to remit payment regarding these services no later than 30 days after said services are billed to me. If any payment is made directly to me by an insurance carrier for services billed by ASSIGNEE, I agree to promptly remit the same to ASSIGNEE. In the event collection action is required to obtain any overdue balance, I agree to pay a 10% penalty to cover said collection fees.

Parent/Guardian: I hereby acknowledge that I have read and understood the information herein, agree with the statements herein, agree to abide by this assignment, release and financial policy, and agree that same are electronically signed by my acceptance of enrollment into ASSIGNEE'S electronic medical record system and I agree to sign original paper agreements in the event that they are requested by any insurance carrier or government bodies.

Patient/Guardian Name (Please Print) _____

Patient/Guardian Signature_____**Date**_____