BEACHSIDE PEDIATRICS

The undersigned agrees, whether he/she signs as guardian agent or as the patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the physician(s).

I agree that should unpaid balances remain, despite attempts to collect, this account be referred to an agency for collection of these unpaid monies owed, plus attorney fees and court costs if applicable.

_____ _____

DATE PATIENTS NAME

_____

PARENT OR GUARDIAN SIGNATURE

AUTHORZATION TO RELEASE INFORMATION AND ASIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

_____ _____

DATE SIGNATURE

I hereby authorize DR_____ to apply for benefits on my behalf for covered services rendered but him/her order. I request that payment from my insurance company be made directly to DR_____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by either me or my insurance company at any time in writing.

_____ _____

DATE SIGNATURE