LIFETIME AUTHORIZATION FOR INSURANCE PAYMENT

I, the undersigned, have insurance coverage and assign directly to South Florida Rheumatology, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize South Florida Rheumatology to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission. I am responsible for any fees or legal fees that South Florida Rheumatology incurs for the full collection of payments.

I have been provided with a notice of Privacy Practices of South Florida Rheumatology, that HIPPA outlines what will be done with my Protected Health Information.

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Patient Name/ Guarantor (please Print) Patient/ Guarantor Date of Birth

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Patient/ Guarantor Signature Date

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South Florida Rheumatology Representative

Authorization

I hereby authorize my insurance company to pay directly to South Florida Rheumatology any and all medical and/or surgical benefits otherwise payable to me for their professional services.

I acknowledge that I am personally responsible and liable to South Florida Rheumatology for any and all medical and/or surgical fees billed by them. Should South Florida Rheumatology accept payment by direct assignment from Medicare or any other insurance company, I understand that I am responsible and liable for any and all deductable expenses and "co-insurance" not covered by Medicare or my primary insurance company. I understand that any overpayment on my part will be refunded to me promptly.

I acknowledge that I am personally responsible for full payment of all "non-covered" services, and I am responsible for all return checks and I agree to pay a $50.00 per check per incident fee for each returned check. If I am placed into collections or I my account goes to litigation, I agree to be responsible for all collection and attorney's fees.

I hereby authorize release of all medical records to my primary care physician, to other physicians to whom I am referred for my care, and to my insurance company or plan.

LIFETIME SIGNATURE: ________________________________

DATE: ______________________

<u>PLEASE NOTE: YOU MUST PRODUCE YOUR INSURANCE CARD TO FRONT DESK AT EVERY VISIT</u>