Assignment of Benefits

Beachside Pediatric Associates

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Beachside Pediatric Associates, P.A.
Dr. Lalitha Vadlamani-Simmers

saving lives - making a difference

Regarding the patient:____ DOB_________________________________

I hereby assign and convey directly to Beachside Pediatric Associates PA, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered. In addition, I authorize my plan administrator to release any and all plan documents in order to claim such medical benefits. I understand and agree to the following terms and conditions:

- **Assignment of Benefits:** I request that payment of authorized insurance benefits be made directly to Beachside Pediatric Associates PA. I understand that I am financially responsible for any deductibles, co-payments, co-insurance and non-covered charges not paid by my insurance provider.
- **Authorization for Release of Information:** I authorize Beachside Pediatric Associates PA to release any medical information necessary to process insurance claims, including but not limited to diagnosis, treatment plans, and procedure codes. This release of information is limited to the extent necessary to obtain reimbursement for services provided.
- **Responsibility for Non-Covered Services:** I understand that some services may not be covered by my insurance plan. In such cases, I am responsible for the full payment of these services. Beachside Pediatric Associates PA will make reasonable efforts to inform me about any potential non-covered services, but it is ultimately my responsibility to verify coverage with my insurance provider.
- **Billing and Payment:** I agree to provide accurate and up-to-date primary and secondary insurance information to Beachside Pediatric Associates PA. I understand that I am responsible for any outstanding balances not covered by insurance. Payment is due at the time services are rendered unless alternative financial arrangements have been made with Beachside Pediatric Associates PA.
- **Changes in Insurance Coverage:** I will promptly notify Beachside Pediatric Associates PA of any changes in my insurance coverage. This includes changes in primary and secondary insurance carriers, policy numbers, dependents or primary care providers.
- **Coordination of Benefits:** I understand that I must list all applicable insurances; my primary, secondary and tertiary for charges to be covered by my insurance. Failure to list all active insurances may result in a patient responsibility of 100% of billed charges and failure to respond to an insurance request for coordination of benefits information in a timely manner will result in a patient responsibility of 100% of billed charges.
- **Out-of-Network Insurance Billing:** If the practice manager has agreed to bill my insurance out-of-network then I will be responsible for the amount not covered by that out-of-network insurance.
- **Assignment of Benefits Authorization Duration:** This assignment of benefits authorization remains in effect until revoked by me in writing or until I no longer receive services from Beachside Pediatric Associates PA.

By signing below, I acknowledge that I have read and understand the terms and conditions outlined in this assignment of benefits document and agree to be bound by them.

Name ____ Relationship ________________________________

Sign ____ Date ______________________________________

Unless revoked, this assignment is valid for all administrative and judicial reviews under healthcare reform legislation, ERISA, medicaid and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.