Encompass Pediatrics LLC

Assignment of Benefits

I hereby authorize and request that payment of benefits made by all the insurance company(s) be made directly to Encompass Pediatrics LLC for medical services rendered to me or my dependent.

I understand that the insurance company may only cover a portion of the total bill. I further understand that I may be responsible for some of the charges as indicated by the insurance company(s) not covered by this assignment.

In addition, I hereby authorize Encompass Pediatrics LLC to disclose any or all written information to my insurance provider and/or its designated representative(s) for reimbursement of services rendered. I hereby release Encompass Pediatrics LLC, its officers, agents, employees, contractors, and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to my insurance provider or their designated representative(s).

By signing this assignment of benefits and release of information I hereby acknowledge:

1. I am aware and understand that this authorization will not be used unless my insurance provider or their designated representative(s) request medical records for reimbursement purposes; or seek to take action regarding payment for services rendered.

2. I agree to participate and assist Encompass Pediatrics LLC or its designated representatives with any appeal process if necessary to collect payments for services rendered.

3. I am aware and have been advised of the provisions of Federal and State statues, rules and regulations and provide for my right to confidentiality of these records.

4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.

5. In the future, a firm contracted by Encompass Pediatrics LLC for billing and collection purposes may do the billing.

6. Encompass Pediatrics LLC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.

7. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.

8. Encompass Pediatrics LLC shall be entitled to the full amount of its charges without offset, if the insurance information I provided; is inactive or false.

Patient/Parent/ Guardian Signature: _____

Print Name: _____

Relation to patient:

Date: _____