

## Assignment of Insurance Benefits

I hereby authorize direct payment of Surgical / Medical benefits to Care One of Florida LLC for services rendered by any practitioner acting as an agent of Care One of Florida LLC. I understand that I am financially responsible for any balance not covered by my insurance, and payments will be made in accordance with Care One of Florida LLC's billing policy.

Initial \_\_\_\_\_

## Authorization to release information

I hereby authorize Care One of Florida LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Initial \_\_\_\_\_

## Consent to Treatment

I am presenting myself for clinic services and I voluntarily consent to the rendering of such care including diagnostic tests and medical treatment by authorized agents and employees of the clinic, and by its medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial to my well being.

Initial \_\_\_\_\_

## Consent to Treat Minor

As the parent/guardian of the above-named child/minor, I hereby give permission to the above named health care provider named above to treat the above-named child/minor. I also agree to be responsible to the health care provider for charges for medical services rendered.

Initial \_\_\_\_\_

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. I have received, read and understand the privacy policy practices used in this office to comply with HIPPA.

Patient (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_

Parent/ Guardian (Please Print) \_\_\_\_\_

Date \_\_\_\_\_

**\*Chief complaint**

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