ASSIGNMENT OF BENEFITS

I understand by signing this form, I am authorizing the following:

1. Assignment of Medicare, Medicaid, Medicare Supplement or other insurance benefits to Neighborhood Pediatrics for treatments, medication(s) and medical equipment furnished to my child by Neighborhood Pediatrics and their medical providers.
2. Direct billing to Medicare, Medicaid or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns, as needed for the limited purposes of processing payments, treatment for Neighborhood Pediatrics operations.
4. Neighborhood Pediatrics and/or any of their affiliates to obtain medical or other information necessary in order to process my claims(s), including determining eligibility and seeking reimbursement for medical treatments, medical supplies and/or medication(s).
5. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include co-payments, and deductibles.
6. Neighborhood Pediatrics and/or any of their affiliates to contact me by telephone or mail regarding my/my child's medical treatments.

Patient Name: __________________________________ DOB:_________________

Signature of Parent, Guardian and/or Patient: __________________________________

Date: ___________________________