



**ASSIGNMENT OF BENEFITS FORM**

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and All Starr Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

**Assignment of Benefits**

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to All Starr Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Authorization to Release Information**

I hereby authorize All Starr Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from All Starr Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

Child/Children(s) Name(s): \_\_\_\_\_  
\_\_\_\_\_