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Manatee Primary Care Associates, LLC
5225 Manatee Ave. West
Bradenton, FL 34209
Phone: (941) 708-8081
Fax: (941) 708-8085

ASSIGNMENT OF INSURANCE BENEFITS

Medicare and Supplemental Insurance

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services ("CMS") and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to Manatee Primary Care Associates, LLC ("The Practice") on my behalf for any services furnished me by or in The Practice, including physician services. I authorize The Practice to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, The Practice may prescribe testing procedures to be performed here. I understand, and have been advised that, according to Florida Law, I am under no obligation to use this facility. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payments due.***

_____ _____

Patient signature Date

Commercial Insurance

I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I request that payment of authorized benefits be made on my behalf to Manatee Primary Care Associates, LLC ("The Practice") for any services provided by The Practice physicians. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with The Practice prior to having my procedure performed. When applicable, I understand that I am responsible for full payment of all charges in the absence of an authorization.***

_____ _____

Patient signature Date