Pediatric Feeding Institute

South Florida

HEALTH INSURANCE ASSIGNMENT OF BENEFITS

Name of Patient: _____ Date of Birth: _____

Name of Policy Holder: _____ Insurance Company: _____

Policy Number: _____ Group Number: _____

I hereby direct the above insurance company to pay to Pediatric Feeding Institute of South Florida, Inc., all medical benefits due to me under policy for covered expenses rendered to the patient identified above. Please make check payable to:

Pediatric Feeding Institute of South Florida

(ADD ADDRESS)

I understand that this authorization applies to those eligible charges submitted in connection with services or supplies furnished only by and though the above provider. In addition, **I understand I am responsible for any and all charges incurred at Pediatric Feeding Institute of South Florida, Inc.,** including any attorney's fees, interest on unpaid balances and all costs of collection resulting from any investigation necessary to collect the claim, not reimbursed through other sources.

****INSURANCE COMPANY—IMPORTANT—PLEASE NOTE****

Your insured, whose name and signature appear below, has by the Assignment directed you to make payment of all benefits for services provided by Pediatric Feeding Institute of South Florida, Inc. directly to Pediatric Feeding Institute of South Florida, Inc. Should you fail to make payments in accordance with this written Assignment, you will not have discharged yourself from liability under the policy identified above, and your remaining obligation to Pediatric Feeding Institute of South Florida, Inc., to the extent that you have violated the terms of this Assignment, may result in you becoming legally obligated to pay the same benefits twice.

Child's Name: _____ **Parent's Name:** _____

Signature of Policy Holder:_____ **Date**_____

www.pediatricfeedinginstitutefl@gmail.com
(add address, phone, fax)