PLACE PATIENT LABEL HERE

MedicalCenter/Clinic
HEALTHCARE CENTERED AROUND YOU

LIFETIME INSURANCE ASSIGNMENT AND AUTHORIZATION FORM

West Florida Medical Center Clinic, P.A. (MCC) is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

Lifetime Insurance Assignment

I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

West Florida Medical Center Clinic, P.A.
8333 North Davis Highway
Pensacola, FL 32514

for all medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MCC and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to MCC. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) MCC accepts Medicare assignment and Medicare payments will be directed to MCC and 2) Medical Center Clinic does not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim and any account balance not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures.

Authorization to Use and Disclose My Protected Health Information

I authorize MCC to use or disclose information about me for the following reasons:

Treatment: MCC may disclose information about me to my primary care physician, referring physicians, and other individuals consulted by my physician so that those involved in my treatment can manage my healthcare needs. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible and genetic conditions to such consultants and/or other healthcare personnel that may be involved in my care. **X Initials of Patient or Legal Representative: _____.**

Payment: MCC may use and disclose information about me to any person or corporation which is or may be liable for all or any portion of the charges incurred in connection with these services, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to any third party payors that may be responsible, in whole or in part, for payment on my behalf. **X Initials of Patient or Legal Representative: _____.**

Operations: MCC may use and disclose information about me as needed to support its business activities. Examples of business activities may include notification of pharmaceutical and medical device recalls, communication about health-related products or services provided by MCC, and quality improvement activities designed to assess and improve the quality and effectiveness of the healthcare and service MCC provides to its patients. If applicable, I expressly consent to MCC's use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to support its business activities.

X Initials of Patient or Legal Representative: _____.

I further agree and acknowledge that:

- My health information is stored in an Electronic Medical Record (EMR) that is shared by MCC health care professionals.
- I have the right to request that you restrict how information about me is used or disclosed for treatment, payment, or operations. I understand that you are not required to agree to these restrictions, but if you do agree, you are bound by the restrictions.
- Should I decline to sign this Lifetime Insurance Assignment and Authorization Form, I assume full responsibility for all charges incurred for services provided at MCC and that these charges are due in full at the time of service.

This Lifetime Insurance Assignment and Authorization is ongoing and will not expire until such time as written notice of revocation is provided.

_____ _____

Signature of Patient or Legal Representative Date