PLACE LABEL OR PRINT PATIENT INFORMATION BELOW

MCC No.: _____

Patient First Name: _____

Patient Last Name: _____

Patient DOB: _____

Date of Service: _____

PATIENT INSURANCE ASSIGNMENT & RESPONSIBILITIES ACKNOWLEDGEMENT

Please read and initial each section and sign acknowledgement below:

Consent to Treatment: I consent to care, treatment, testing, and all other services performed by healthcare providers at Medical Center Clinic. I understand that I have the right to refuse any proposed care, treatment, testing, surgery, or other procedure. I understand that I have the right to ask questions and discuss my care with my healthcare provider. **Initials of Patient or Legal Representative: _____.**

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. **Initials of Patient or Legal Representative: _____.**

Patient Financial Responsibility Policy: Co-payments, deductibles, co-insurance, and all other appropriate payment will be due at time services are rendered. Insurance companies require physician offices to collect all applicable patient portions prior to services being rendered. **Initials of Patient or Legal Representative: _____.**

Tobacco-Free Campus: Use or sale of tobacco products (cigarettes, including electronic; cigars; pipes; and smokeless tobacco) is prohibited on all Medical Center Clinic premises, campuses, parking lots and grounds. **Initials of Patient or Legal Representative: _____.**

I acknowledge and understand the above notices and assignments and will comply with all specified responsibilities.

_____ _____
Signature of Patient or Legal Representative Date