KINGS HIGHWAY MEDICAL PC

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to KINGS HIGHWAY MEDICAL for any services furnished the patient listed above by KINGS HIGHWAY MEDICAL and health care providers, and I assign my right to receive these payments to KINGS HIGHWAY MEDICAL to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan will not direct payment to KINGS HIGHWAY MEDICAL, I agree to forward to KINGS HIGHWAY MEDICAL all health insurance payments, which I receive for the services rendered by KINGS HIGHWAY MEDICAL and its health care providers.

I authorize KINGS HIGHWAY MEDICAL or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

Parent/Person Legally Responsible_____

Relationship to Patient _____

Date _____

Other Health Insurance

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.

Parent/Person Legally Responsible _____

Relationship to Patient _____

Date _____

Patient Responsibility

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. To the extent no coverage exists under my Health Insurance Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse KINGS HIGHWAY MEDICAL for all costs, expenses and attorney's fees that may be incurred by KINGS HIGHWAY MEDICAL to collect those charges.

Parent/Person Legally Responsible _____

Relationship to Patient _____

Date _____