



ROWAN TREE MEDICAL, P.A.  
2500 NE 15<sup>th</sup> Avenue  
Wilton Manors, FL 33305  
(954) 533-5382

## ASSIGNMENT OF BENEFITS

### Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Rowan Tree Medical, P.A. and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Rowan Tree Medical, P.A. of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Rowan Tree Medical, P.A. and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

### Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Rowan Tree Medical, P.A. for all covered medical services and supplies provided to me during all courses of treatment and care provided by Rowan Tree Medical, P.A. and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Rowan Tree Medical, P.A., and will constitute a continuing authorization, maintained on file with Rowan Tree Medical, P.A., which will authorize and allow for direct payment to Rowan Tree Medical, P.A. of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Rowan Tree Medical, P.A..

### Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Rowan Tree Medical, P.A. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Rowan Tree Medical, P.A.. Patient/Insured (Printed Name)

### Missed Appointments

I understand that if I am unable to make my scheduled appointment, it is my responsibility to contact Rowan Tree Medical 24 hours in advance. I understand that I will be responsible for a "NO SHOW" fee of \$25.00 if I miss a scheduled appointment without notifying the office.

Patient/Insured (Name)

Date of Birth

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Patient/Insured (Signature)

Date of Signature

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Witness (Signature)

Date of Signature

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