Assignment of Benefits

I hereby assign to COASTAL SPINE & PAIN CENTER, all my rights, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, and personal injury protection, rendered by the assignee as described in the attached medical claim form.

I acknowledge that I am still responsible for paying the above referenced group if the relevant insurer, plan, or payor does not pay the physician in full at their billed amount, in accordance with **Florida Statue 627.736 (5).**

Policy Name: ______________________________ Policy Number: ______________________________

Signed: ___________________________________ Date: ______________________________________

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient (to the extent minor could not have consented to the care)
( ) Guardian or conservator of patient
( ) Beneficiary or personal representative of deceased patient
( ) Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

Physician Signature: ____