Lakeside Endocrine Associates, Inc. Tel: (386) 274-1414 FAX: (386) 274-2215
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RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT, AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Lakeside Endocrine Associates, Inc. to release any information necessary to process my insurance claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance claim for the period of LIFETIME. I claim any insurance benefits due to me for services rendered by Lakeside Endocrine Associates, Inc. and authorize and direct my carrier to issue payment check(s) directly to Lakeside Endocrine Associates, Inc. regardless of my insurance benefits, if any. I understand that I am fully financially responsible for any fees incurred, and I agree to pay such fees in full.

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result to non-payment by any carrier.

Patient's Name: _____

Signature: _____ **Date**: _____

Authorized Signature (if minor) : _____

Relationship to Patient: _____

For your convenience, we can bill your credit card after the insurance company has determined the amount you owe:

Copays, co-insurance and deductibles will still be due at the time of service rendered.

Name as it appears on card:
_____

Credit Card Number: _____

Expiration Date: _____

Signature of Credit Card Holder: _____

Today's Date: _____