Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Delavan Pediatrics, LLC for medical or surgical services or items rendered to me or my dependent by Delavan Pediatrics, LLC. Should my insurance carrier deny Delavan Pediatrics, LLC payment, I understand that I am financially responsible for the charges. I authorize Delavan Pediatrics, LLC to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Signature ____ Date ____________________