Patient Liability Form

Miami Pediatric Care, LLC

I agree that should this account be referred to an attorney or agency for collections that I will be responsible for all collection cost, attorney fees and court cost.

I, _____ hereby authorize my insurance carrier to pay directly to my physician the surgical and / or medical benefits, if any, otherwise payable to me for this services, but not to exceed the charges for those services, I understand that I am financially responsible for those charges not paid by my insurance.

I authorize the release of any medical information necessary to process the claims.

Signature: _____ Date: _____