

WEST FLORIDA MEDICAL GROUP

Assignment of Benefits

I hereby assign to West Florida Medical Group any insurance or other third-party benefits available for health care services provided to me. I understand that West Florida Medical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to West Florida Medical Group, I agree to forward to West Florida Medical Group all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____