CLIVE B. RAYNER, D.M.D. and Associates
Oral Facial Surgery of Orange Park
2301 Park Avenue, Suite 101
Orange Park, Fl. 32073

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

*Our professional services are rendered to you, **not the insurance company**. Therefore, payment for treatment is your responsibility.*

Please read and sign the following:

1) I authorize this office to release or receive any information necessary to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.
5) Additionally, I authorize the release of all medical information in my records to other health care providers as deemed necessary by Dr. Rayner & other health care providers for my health & welfare.
6) I acknowledge receipt of this office's **Notice of Privacy Practices**.

I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within **60 days**, it is **my responsibility** to pay my doctor's bill directly.

I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

There will be a service charge on all returned checks and delinquent accounts may incur interest charges. A cancellation charge will be incurred unless 24-hour notice to Dr. Rayner is given.

A photostatic copy of these authorizations and agreements shall be as valid as the original.

Signature____Date______________________

Witness____

PLEASE PRESENT BOTH YOUR INSURANCE CARD AND YOUR DRIVER'S LICENSE, SO WE MAY MAKE A COPY FOR YOUR RECORDS.