

CAREMED OF FLORIDA
11268 S. Apopka Vineland Rd
Orlando, FL 32836

NAME: LAST(Apellido)_____ **FIRST**(Nombre)_____ **MI**_____

STREET ADDRESS (Direccion)_____

CITY (Ciudad)_____ **STATE**_____ **ZIP**_____

PHONE: HOME (Telefono)_____ **CELL**_____

EMAIL:_____ **MARITAL STATUS** (Estado Marital) S M D W

BIRTHDATE_____ **AGE**(Edad)_____ **SEX**(Sexo) M F **SS#**(Seguro Social)_____

EMPLOYER (Emplea)_____ **WORK #**(Telefono)_____

RELATIVE NOT LIVING WITH YOU (Que no viva en el mismo hogar)_____

ADDRESS OF NEXT OF KIN (Direccion del familiar cercano)_____

IF MINOR PARENTS SS# (Si menor los Padres ss#)_____

INSURANCE INFORMATION (Informacion del Seguro)

PRIMARY (Primario)_____ **SECONDARY**(Secundario)_____

ADDRESS (Direccion)_____

TYPE OF INSURANCE(HMO, PPO, ETC.):_____ **START DATE:**_____

INSURED ID #:_____ **GROUP #:**_____

ASSIGNMENT OF INSURANCE BENEFITS (Informacion de Beneficio)

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENT(S). I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICE RENDERED, OR FOR SERVICES TO BE RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENT(S), AND THAT I WILL BE BOUND BY THIS SIGNATURE THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I _____ HEREBY AUTHORIZE _____
TO PAY AND HEREBY ASSIGN DIRECTLY TO CAREMED OF FLORIDA ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED ON THE ATTACHED FORM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.

I FURTHER ACKNOWLEDGE THAT ANY INSURANCE BENEFITS, WHEN RECEIVED BY AND PAID TO CAREMED OF FLORIDA WILL BE CREDITED TO MY ACCOUNT, IN ACCORDANCE WITH THE ABOVE SAID ASSIGNMENT. **I AGREE TO PAY ALL CHARGES INCURRED AT TIME OF VISIT WHEN THERE IS NO INSURANCE INVOLVED. UNLESS I HAVE PAID MY BILL IN FULL, I HEREBY AUTHORISE CAREMED OFFICE TO DO A CREDIT CHECK.**

AUTHORIZED SIGNATURE OF SUBSCRIBER (Firma de Suscriptor)

DATE (Fecha)