PHILIP REID ORANBURG, M.D., P.A.
CARDIOVASCULAR MEDICINE
PHILIP R. ORANBURG, M.D., F.A.C.C.

Assignment of Benefits
Authorization to Release Medical Information
Consent to Treatment

Last Name_____ First Name_____

I hereby assign all medical benefits to which I am entitled to Philip Reid Oranburg, MD, PA. In the event Philip Reid Oranburg, MD, PA files an insurance claim on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance company. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount, owing as well all reasonable costs associated with the collection of this debt. This includes but is not limited to: collection service fees, attorney's fees, all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old.

I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Philip Reid Oranburg, MD, PA as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except for acts of negligence.

Authorized Signature _____

Today's Date _____

GLADES MEDICAL PLAZA
1590 N.W. 10th AVENUE, SUITE 404 • BOCA RATON, FLORIDA 33486 • (561) 391-5800 • FAX (561) 338-9251