

Assignment of Benefits / Payment Agreement

I authorize payment of medical benefits to South Florida Cardiovascular Surgical Associates, P.A. for services furnished to me by Richard Brezing, M.D., Harold G. Roberts, Jr., M.D., Marek Zalewski, M.D., Robert A. Green, M.D., Mario Martinasevic, Barry Crowe, M.D., or Marco Bologna, M.D. In addition, I authorize the release of any information necessary to obtain payment.

I understand that I am financially responsible for all charges incurred. In the event I fail to make payment for services rendered, I will be responsible for all collection/attorney fees, court cost and any additional fees that may be incurred to collect any outstanding balance.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Signed _____ Date _____