



AUTHORIZATION / CONSENT FORM

Patient Name (Please Print) _____

INSURANCE YEARLY AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Securities Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or other carriers any information needed for benefits made on my behalf. I assign this organization to submit a claim to Medicare AND/OR OTHER CARRIERS for services rendered. I request that this authorization also apply to all other insurance plans.

Signed _____ Date _____

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL RECORDS/CONSENT TO TREAT

I give my consent for treatment to this physician(s) and in the course of this treatment should it be necessary to consult with others, I hereby give my permission and consent for this organization to obtain and release medical records and other pertinent information on the above patient to/from other healthcare providers or agencies including information regarding Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) test results as it relates to the medical care and treatment provided to the above patient.

Signed _____ Date _____

TERMS OF PAYMENT FOR RENDERED SERVICES

Unless prior arrangements are made and agreed to by the physician's office, payments shall be made when services are rendered.

I hereby authorize and request that all hospital, medical and/or surgical benefits be paid directly to this physician for the services and items provided to the above patient. When a claim is submitted as an unassigned claim, I also authorize payment to be issued directly to this organization the amount due me in my pending claim for services of medical treatment.

I agree to pay any collection agency fees including reasonable attorney fees, whether at trial appeal or otherwise incurred, should the undersigned fail to pay all sums due the physician's office.

I also consent to pay a \$25 return check fee for each check in the event I present a personal check that is returned by the physician's office's bank for having insufficient funds.

The laws of the State of Florida shall govern the interpretation, construction and enforcement of this agreement.

Signed _____ Date _____

If signed by someone other than the patient, please indicate the relationship to the patient:

_____ parent _____ legal guardian _____ legal representative