HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received Florida Medical Associates, LLC HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION-I, the below named patient, do hereby authorize any physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g. Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASIGNMENT- I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIIXIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. The assignment will remain in effect until revoked by me in writing.

CONSENT FOR TREATMENT- I, the below named patient hereby give my consent for treatment to all physicians associated with Florida Medical Associates, LLC.

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Florida Medical Associates, LLC. To discuss my medical condition with, or release my medical records to the below named person (s):

NAME ____ Relationship to Patient ____________________________

NAME ____ Relationship to Patient ____________________________

NO SHOWS/ LAST MINUTE CANCELLATIONS/ LAST MINUTE RESCHEDULES: Providers and staff of Florida Medical Associates LLC rely on the pre-scheduled appointments to plan their day to day activities. Last minute reschedules or cancellations and no-shows disrupt the daily activities and also curtail the ability to schedule another member/ patient in your pre-scheduled slot. If you have to cancel or reschedule your appointment, please provide us with at least 48 hour prior notice. If you reschedule, cancel or are a no-show to your pre-scheduled appointment, we may charge a $25.00 fee directly to you. Please note that this charge will not be billed to any third party (including your insurance) but directly to you and you will be responsible for payment of this charge prior to any further encounters.

COLLECTION AGENCY- In the event your account becomes delinquent and is turned over to a collection agency and/or attorney, you will be financially responsible for all associated collection fee and legal fees that Florida Medical Associates, LLC incurs through the process utilized to collect the delinquent balance. Please be aware if your account is turned over to a collection agency you can de discharged from the practice.___________

RETURNED CHECK-Checks returned to Florida Medical Associates, LLC by the bank will be assessed a return check fee, in addition to the original amount of the check. You have ten (10) days to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time the check will be sent to the States Attorney's Office for further collection. ___________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days.

DATE __________________ PATIENT ____

(Signature)

SUBSCRIBER (If different from patient) ____

(Signature)