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Phone : 407-476-9066
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AUTHORIZATION , ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE.

I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company, and other medical professionals and institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate or make payment of a claim, and to review records for quality improvement initiatives, audit compliance , utilization management and complaint resolution. I authorize payment directly to Internal Medicine & Healthy Lifestyle for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments , co-insurance, deductibles and non-covered services. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature : X_____ Date : _____

FINANCIAL AGREEMENT

I understand that I'm directly responsible for all the charges incurred for medical services for myself and my dependents regardless of insurance coverage. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements.Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I furthermore agree to pay legal interest, collection expenses and attorney fees incurred to collect any amount I owe. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable.
AGREEMENT: This above information is for the purpose of obtaining credit and is warranted to be true.
CANCELATION POLICY: If you have any inconvenience for showing to your appointment please call us at least 24 hours before your appointment, in order to reschedule it. Our no-show fee will be $ 40, and it has to be paid before your next appointment.

Signature : X_____ Date : _____

REQUEST FOR TREATMENT

I authorize the group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physician of the nature of any proposed procedure and any available alternatives, methods or treatment together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physician to provide according to recognized standard of medical practice, and I acknowledge that the group and its personnel are responsible for providing this information.

Signature : X_____ Date : _____
Patient/ Parent / Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Internal Medicine Services LLC (dba Internal Medicine & Healthy Lifestyle) . Our Notice of Privacy Practices information about how we may use and disclose your protected information. We encourage you to read it carefully. Our Notice of Privacy Practices is subject to change.

Signature : X_____ Date : _____
Patient/ Parent / Guardian

X_____ _____
Name of Patient or Representative (Print Please) Relationship to Patient

Office use : We attempted to obtain written acknowledgement, but couldn't be obtained for the following reason:
- ❑ Patient or Representative refused to sign
- ❑ Emergency situation prevented signature
- ❑ Other :_____
- ❑ Initials of Employer :_____