

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may Deem necessary to the patient name above.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

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INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida Physicians Medical Group. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

PATIENT'S SIGNATURE

DATE

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FOR MEDICARE PATIENTS ONLY

MEDICARE PART B SIGNATURE AUTHORIZATION FOR LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's Intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

PRINT PATIENT NAME

MEDICARE PART B NUMBER

PATIENT'S SIGNATURE

DATE

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AUTHORIZATION OF MEDICAL RECORDS

Do you authorize the release of medical records to your Primary care doctor? yes no
Do you authorize the release of medical records to your Referring Physician? yes no

PATIENT'S SIGNATURE

DATE

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ADVANCE DIRECTIVE

(LIVING WILL, DURABLE POWER OF ATTORNEY, DESIGNATION OF A HEALTH CARE SURROGATE)

I understand that the terms of any Advance Directive that I have executed will be followed by the Health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

 I HAVE executed an Advance Directive.

 I HAVE NOT executed an Advance Directive

PLEASE PROVIDE COPIES OF ADVANCE DIRECTIVE/LIVING WILL TO THE RECEPTIONIST TO BE INCLUDED IN YOUR MEDICAL RECORD