

PATIENT: _____ **DOB:** _____ **SS#** _____

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, knowing that I am (the patient is) suffering from a condition requiring medical care, do hereby present myself for treatment at Florida Hospital Memorial Medical Center, **Julie Schneider, M.D.**, and voluntarily consent to the rendering of such care, including treatments, photographs for treatment evaluations, administration of anesthetics and performance of diagnostic and/or surgical procedures. In the event a medical device is implanted or explanted, I agree to the release of my Social Security number to the manufacturer/FDA for tracing of the device. I understand that I am under the care and supervision of my attending physician (or in the emergency department, the emergency department physician) and it is the responsibility of the hospital and its staff to carry out the instructions of such physician(s). I understand that the physicians furnishing services to me may be employees of the hospital or may be independent contractors and not employees or agents of the hospital, and that all physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examination in the office or hospital.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Florida Hospital Memorial Medical Center, **Julie Schneider, M.D.**, and the physicians accepting this assignment of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Florida Hospital Memorial Medical Center and their physicians for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Florida Hospital Memorial Medical Center, its officers and employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Florida Hospital Memorial Medical Center, **Julie Schneider, M.D.**, and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Florida Hospital Memorial Medical Center, **Julie Schneider, M.D.**, from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or /or Title XIX 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 its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Florida Hospital Memorial Medical Center physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not (initials) _____ cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to **INPATIENT:** (lotion, toothpaste, deodorant, etc.) **OUTPATIENT AND EMERGENCY:** medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Florida Hospital Memorial Medical Center, **Julie Schneider, M.D.**, as dated below and does not waive any of my right to request a review of make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE IN FLORIDA HOSPITAL MEMORIAL MEDICAL CENTER.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Florida Hospital Memorial Medical Center physician(s) in accordance with the regular rates and terms of the physicians(s). Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

Patient's signature

Patient's representative/policy holder or spouse
Indicate relationship _____

Witness

Date

Patient unable to sign due to: _____