Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Diabetes and Endocrine Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Diabetes and Endocrine Associates. I understand that diagnosis or treatment of me by Florida Diabetes and Endocrine Associates may be conditioned upon my consent as evidenced by my signature on this document.

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Diabetes and Endocrine Associates.

Assignment of Benefits:

I hereby assign, grant and transfer to Florida Diabetes and Endocrine Associates, now and in the future, all of my rights and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third---party payer for those costs I incur in receiving services from Florida Diabetes and Endocrine Associates. The included insurance policies and insurer would include, but are not limited to, health, auto, UM and PIP; and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to Florida Diabetes and Endocrine Associates was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to Florida Diabetes and Endocrine Associates the amount due me in any potential or pending claim for medical benefits under the respective policies, expressly including all PIP policies. I agree that should the amount received Florida Diabetes and Endocrine Associates be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services by Florida Diabetes and Endocrine Associates are not covered by said insurance policy, I am responsible to Florida Diabetes and Endocrine Associates for payment of the entire bill.

Financial Responsibility

This is an agreement between Florida Diabetes and Endocrine Associates, a Florida Corporation, as a creditor, and the Patient/Debtor named on this form.

In this agreement the words “I”, “you,” “your,” and “yours” mean the Patient/Debtor. The word “account” means any account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Florida Diabetes and Endocrine Associates and/or its affiliated entities.

Insurance: Insurance is a contract between you and your insurance company. In some cases exact

insurance benefits cannot be determined until the insurance company receives the claim. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fact, insurers will routinely stall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of Florida Diabetes and Endocrine Associates. We will NOT under any circumstance falsify or change a diagnosis or symptom in order to convince an insurer to 'pay' for care that is not covered, nor do we delete or change the content in the record that may prevent, or cause, it to be considered covered.

I understand that Appointment Reminders are a courtesy. Failure to show up for, or cancelation of an appointment with less than 24 hour notice, may result in a no show or same day cancellation fee assessed to my account. The no show or same day cancellation fee is $35.00. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be discharged from Florida Diabetes and Endocrine Associates practice location.

I understand that additional administrative charges may apply for items such as the completion of medical forms, telephone consultations, and physician letters. For copy of medical records, there is $1.00 per page for paper records for the first 25 pages and $0.25 for each page in excess of 25 pages and/or a $2.00 charge for non-paper record, plus any applicable postage. Please note that this office does not complete FMLA or disability forms; these forms will need to be filled out by your primary care provider.

(This is not an exhaustive list)

Self Pay Request

If I choose to be a "self pay", I understand I will be required to pay full amount due to Florida Diabetes and Endocrine Associates for my visit at the time of service.

Request to Restrict Use and Disclosure of Protected Information

I understand if I want to request restriction on release of my health information to my insurance company(ies), I have to complete Request to Restrict Use and Disclosure of Protected Information form which will be provided to me on my request.

Guarantee Of Payment:

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay Florida Diabetes and Endocrine Associates all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co---payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge, time of visit or upon presentation of the first bill by Florida Diabetes and Endocrine Associates. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. I understand and agree that if Florida Diabetes and Endocrine Associates is required to bring a claim or file an action to enforce this agreement, Florida Diabetes and Endocrine Associates shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed

Florida Diabetes and Endocrine Associates for its services. Based on permissible purpose under the Fair Credit Reporting Act, Florida Diabetes and Endocrine Associates reserves the right to run a credit report for the sole purpose of determining my ability to meet incurred expenses directly related to my treatment.

Payments received will be posted to the oldest outstanding balance on your account.

Returned Checks: A Returned check will result in a service fee based on the face value of the check and may require all future payments to be made by cash or credit card. In addition, you will be responsible for any bank fees that may occur on returned checks. A collection agency may be used in the recovery of debt attributed to returned checks, in addition to the payment of the check plus any court cost, reasonable attorney fees and any bank fees incurred by the payee in taking action as pursuant to Florida Statute 68.065.

Divorce, Dependent and Child Custody Cases: Regarding divorce, the presenting guardian accompanying the person (minor or disabled adult) who receives care at Florida Diabetes and Endocrine Associates is responsible for payment of copays, co-insurance and/or deductibles at the time of service.