FLORIDA FAMILY TELEHEALTH **TELE-EMC**

Patient Consent, Authorization, and Assignment of Benefits

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I further acknowledge that in the event Florida Family Telehealth is forced to retain the services of a collection agency and/or attorney, I will be responsible for the collection and/or legal fees.

I hereby authorize the Nurse Practitioner to release medical information to my insurance company to secure payment of benefit.

I also authorize the use of my signature on all insurance submissions and as authorization for payment to be sent to *Florida Family Telehealth, 609 Lexington St, Dunedin, Florida, 34698*.

I hereby consent to the following treatments: administration and performance of all treatments, the performance of such procedures, use of prescribed medication, and the performance of diagnostic procedures/tests and cultures as may be deemed necessary or advisable in the treatment of this patient. Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the nurse practitioner or her assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis or treatment. The consent will remain in full force until revoked in writing.

I, the undersigned, acknowledge that Florida Family Telehealth will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the notice of privacy practice. A photocopy of this consent shall be considered as valid as the original Medicare patient's.

I authorize Florida Family Telehealth to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims.

I acknowledge that I have been given Florida Family Telehealth's notice of privacy practices. I understand that if I have questions or complaints, I should contact the privacy officials.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO FLORIDA FAMILY TELEHEALTH.

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my automobile insurance, a/k/a Personal Injury Protection and Medical payments policy of Insurance to the above caption healthcare provider, I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payments at the time services are rendered. I understand this document will allow the provider to file suit against the insurer for payment of the insurance benefits and to seek damages from the insurer per Florida statute 627.428.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, have received a copy of Florida Family Telehealth's Notice of Privacy Practices. The Nurse Practitioner and staff of Florida Family Telehealth have my permission to speak to any family/friends I designate in writing in reference to my medical care.

NAME OF RESPONSIBLE PARTY

SIGNATURE OF RESPONSIBLE PARTY