PRIMARY CARE SPECIALISTS OF FLORIDA
721 W COLONIAL DR
ORLANDO, FL
ZIP 32804
Tel: (407) 735-6735
Fax: 1-855-618-2347
www.pcsfmed.com

CONSENT FOR EVALUATION AND TREATMENT

I agree to allow Primary Care Specialists of Florida, LLC and its Physicians to provide all healthcare services to me that are routine or otherwise deemed necessary. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to receiving it. I understand that any treatment involving material risks will be explained to me and that I will have the opportunity to ask questions about the associated risks, alternatives and prognosis before allowing the treatment to be performed. I agree that no guarantees have been given to me as the outcome of any treatment. I agree that my picture can be taken to identify me.

Patient Signature ______________________ Date ____________

INSURANCE ASSIGNMENT

I permanently assign my third-party payer benefits payable directly to Primary Care Specialists of Florida, LLC. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

I understand and agree that payment of my out-of-pocket portion for all elective services must be paid within 15 days prior to receiving the services or the service will be canceled and then rescheduled when such payment is received. If I do not pay for all of my services and an attorney or collection agency asks me to pay, I agree to pay the reasonable attorneys fees and or collection expenses in addition to paying for the cost of all my services.

I authorize Primary Care Specialists of Florida, LLC to file an appeal on my behalf for any denial of payment and or adverse benefit determination related to services and care provided. If my health insurance or third-party payer will not direct payment to Primary Care Specialists of Florida, LLC I agree to forward all health insurance payments which I receive for services rendered to Primary Care Specialists of Florida, LLC.

Unless otherwise designated by the payer, I understand Primary Care Specialists of Florida, LLC posts all payments received to the oldest balances first with the exception of copays, drugs, and supplies. I give permission to apply any credit balance to offset amounts due to Primary Care Specialists of Florida, LLC for current accounts or accounts I have not paid yet.

I authorize the use for my signature below on all Insurance submissions. I may at any time in the future cancel this authorization in writing.

Patient Signature ______________________ Date ____________