HOPE CENTERS OF CENTRAL FLORIDA

HOPE CENTERS
OF CENTRAL FLORIDA
HEALING • TRANSFORMING • EMPOWERING HOPE

Date:_____

Patient Information

Name:_____ Social Security:_____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone Number: _____ Alternate Phone Number: _____
Race:_____

Sex:☐ M☐ F Age:_____ Birth date: _____☐ Single ☐ Married ☐ Widowed☐ Separated☐ Divorced

Patient Employed by _____ Occupation:_____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of an Emergency who should be notified? _____ Phone: _____

Hope Centers of Central Florida
Financial Statement & Authorizations

It is the policy of this practice that payment in full is due at the time services are rendered. We are happy to accept your payment by: check, cash, Visa, MasterCard, Discover or American Express. We will submit claims to those insurance companies with whom we have a contract; however it is the sole responsibility of the insured to know the type of insurance, assigned primary care physician and copays or deductibles. All other patients will be given receipts that will be sufficient to submit to an insurance company for reimbursement. **All co-pays, deductibles, and coinsurances are due at the time services are rendered.** In the event you are not prepared to pay at the time of service you may be asked to reschedule if your needs are not medically urgent. For hospitalizations the office will file the charges to all insurance companies as a courtesy, however financial responsibility remains with the patient. Any balances that are over **90 days** past due will be turned over to a collection agency unless previous arrangements have been made.

Your Signature Will Serve for All of the Following

Consent: I hereby give consent to Hope Centers of Central Florida to provide necessary treatments discussed. I have been offered a copy of the Privacy Policies for Hope Centers of Central Florida and authorize use/disclosure of information to coordinate and/or manage my healthcare and any related services, receive payment for services and perform general healthcare operations including receiving email notices regarding practice services and appointment reminders via text, phone call and/or email.

Medical Release: I authorize any holder of medical or other documentation about me to release to Hope Centers of Central Florida, independent laboratories and insurance carriers any information needed for claims processing & payments. I permit a copy of this authorization to be used in place of the original.

Insurance Assignment: I authorize payment of medical benefits to the attending physician/practice for services.

Financial Responsibility: I understand that I am ultimately responsible for all charges incurred. It is my responsibility to provide the office with all necessary information to file insurance claims, and to notify the office of changes in coverage prior to any visits. **I understand that it is my responsibility to know my insurance coverage and benefits, including contracted laboratories/hospitals where I may receive care.** I will be responsible for any charges not covered by my insurance policy, including a $25.00 fee for "no show" appointments , special documents I request to be completed or telephone consultations, all of which I acknowledge are not billable to insurance. Additionally I understand that I will be charged fees for medical record copies as per the Florida statute allowance. I understand the above financial statement of timely payment. I understand that any returned checks may be re-deposited electronically, including all fees assessed.

Signature:_____ Date:_____