DIABETES & ENDOCRINE CENTER OF ORLANDO, P.A.

3113 LAWTON ROAD, SUITE 100 – ORLANDO, FL 32803

407-894-3241

PATIENT: _____ DOB: _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient named above.

_____ _____

PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Diabetes & Endocrine Center of Orlando, PA. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

PATIENT SIGNATURE DATE

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

( ) I HAVE executed an Advance Directive. (Living Will, Durable Power of Attorney, Desig. of a Health Care Surrogate)
Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

( ) I HAVE NOT executed an Advance Directive. (Living Will, Durable Power of Attorney, Desig. of a Health Care Surrogate)

_____ _____

PATIENT SIGNATURE: DATE

FOR MEDICARE PATIENTS ONLY – MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII 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 intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____

PATIENT NAME PATIENT SIGNATURE

_____ _____

MEDICARE HIN# DATE