Insurance and Financial Agreement/ Assignment of Benefit/Patient Responsibility

Insurance Pre-Certification
I under that I am responsible for any required notification needed by my insurance company in order to pay for services rendered. If this not done, my benefits maybe reduced and I am responsible for all non-covered charges.

Assignment of Benefits
I hereby assign to **SUNCOAST PREMIER MEDICAL LLC** any and all benefits from my insurance plans or any other protection maintained by the patient. I authorize and direct such benefits to be paid directly to **SUNCOAST PREMIER MEDICAL LLC** for services provided. If my insurance plan does not uphold the agreement to pay a claim on my behalf within 30 days of filing, I authorize **SUNCOAST PREMIER MEDICAL LLC** file a complaint to the Insurance Commissioner in order to be reimburse for professional services.

Financial Agreement

I, __________________ understand all patients are financially responsible for all services rendered by **SUNCOAST PREMIER MEDICAL LLC**. Patients with **NO** Insurance are to pay in full at the time of service. Insurance must be verified and approved prior to acceptance, although this is **NOT** a guarantee of payment form your insurance company. **Office visits, Co-pays, deductibles, and other services not covered by your insurance are to be paid in full at the time of your service. You the Patient remain responsible for payment for services if your insurance company has not paid your claim within 45 calendar days.**

This facility does use legal means provided by law to collect bad debt accounts and returned checks. Returned checks may be directly withdrawn from your account with a fee applied.

Consent for Medical Services

I, ________________________ consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by **SUNCOAST PREMIER MEDICAL LLC**.

I hereby give my permission and consent for **SUNCOAST PREMIER MEDICAL LLC** and staff to treat me using generally accepted standards of medical care. I am aware that medicine and surgery are not exact sciences and no guarantee for successful outcome has been made nor implied to me. I understand that treatment for my condition(s) will be based upon the information that I provide. I accept full responsibility should I provide inaccurate, incomplete, or misleading information. I certify that the identifying information and address, and telephone information is correct and agree to provide **SUNCOAST PREMIER MEDICAL LLC** and its staff if such information changes or becomes outdated. I understand that **SUNCOAST PREMIER MEDICAL** cannot contact me if I have provided incorrect or illegible information or should I not keep this information current and correct.

The undersigned certifies that He/She has read and understands s the above and fully accepts all specified terms therein.

The undersigned also certifies that He/She has read and understands the Patient Responsibilities Notification provided by **SUNCOAST PREMIER MEDICAL LLC**.

____ ______________
Signature of patient or authorized legal representative Date

____ ______________
Signature Date