LANGER FAMILY MEDICINE, P.A.
1806 Short Branch Drive, Suite 101
New Port Richey, FL 34655-4426
Phone: (727) 372-0873

PERMISSION FOR TREATMENT

I; the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by Langer Family Medicine, P.A. deemed advisable and necessary in the diagnoses and treatment of my condition. I am aware that practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records for treatment.

Signature:_____ **Date:**_____

AUTHORIZATION and ASSIGNMENT

I request that the payment of authorized Medicare/insurance benefits be made either to me or on my behalf for any services furnished by Langer Family Medicine, P.A.. I authorize any holder of medical information about me to release to CMS/insurance carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize Langer Family Medicine, P.A. to furnish information Medicare/insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to Langer Family Medicine, P.A. for medical/diagnostic, surgical benefits payable for the services rendered. I understand that any unpaid balances not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the professional services rendered. I understand that I am responsible for any charges incurred in my account and if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services. I certify that the information I had given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or in above information.

Signature:_____ **Date:**_____

DESIGNED CONTACT

I authorize discussion of my general medical condition and diagnoses (including treatment, payment and healthcare operations). Please list the family members or significant others, if any, whom we may inform about your medical condition. **Emergency Contact** is a Designated Contact unless you check **Emergency Contact Only**.

Emergency Contact: _____ ☐ **Emergency Contact Only** **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Signature:_____ **Date:**_____

PRIVACY NOTICE

I have received a copy of Langer Family Medicine, P.A.'s office privacy notice as required by HIPPA.

Signature: _____ **Date:**_____

Patient's name (print):_____

Witness:_____ **Relationship:**_____

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GENERAL PATIENT/PHYSICIAN AGREEMENT

Please read the following paragraphs, sign each paragraph stating that you have read, understand, and agree to the same.

CONFIDENTIALITY

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient as long as confidentially is kept at the physician level. I have read, understand, and agree with the above.

Patient or Guardian Initials: _____ **Date:** _____

FORM COMPLETION AND COPIES POLICY

The ever-increasing time and cost burden required to complete the multitude of forms being requested by our patients requires Langer Family Medicine PA to implement the following charge policy for all forms.

- Completion of one (1) form page = $25
- Completion of two (2) or more form pages = $50 (maximum charge)
- Completion of Attending Physician Statement = $50
- Copies up to 25 pages$1.00 per page and .25 cents after per page (no maximum)

Forms that will be charged a completion fee include FMLA (Family and Medical Leave Act) forms, Disability forms, Attending Physician Statement and other miscellaneous forms. You will be notified upon the completion of your form(s) and the fee associated with them. The fee will need to be paid by cash or check before the forms are released.

Patient or Guardian Initials: _____ **Date:** _____

NO SHOW FOR A SCHEDULED APPOINTMENT

Langer Family Medicine, PA will call your primary phone 1-2 business days prior to next appointment to confirm your visit date and time. **If you are unable to make your appointment and do not contact our office 24 hours in advance to cancel, a $50.00 charge will be posted to your account.**

Patient or Guardian Initials: _____ **Date:** _____

CONTACT INFORMATION

Email Address: _____

Cell Phone: _____

Any additional changes in your personal information:

_____

_____