1132 Cypress Glen Circle Kissimmee, FL 34741
Phone: 407-343-4700 Fax: 407-343-8500

CONSENT AND AUTHORIZATION

- **MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. We do not give one year prescription refills. The practice is closed on weekendand refill requests will not be accepted. Please contact our office to confirm that we have received the refill request.

- **PAYMENTS & CREDIT CARD ON FILE:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. All patients are required to leave a credit card on file. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

- **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

- **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or any other applicable forms, there is a fee starting at $35. Fees are due when forms are drop off. Please allow 7 to 20 business days for us to completed forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

- **APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals later than 15 minutes will require appointment rescheduling.

- **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

- **CANCELLATION/NOSHOWS:** If you need to cancel your appointment, we ask that you give us 24 hours notice. If you fail to notify us and miss your appointment, there will be a $35 fee and possible termination from the office if excessive. There will also be a fee of $35 if you cancel your appointment on the same day.

- **LAB & RADIOLOGY RESULTS:** Once reports are received, the physician will review the results and have our clinical staff contacts you within 10 business days.

- **Terminating Patient Relationships reasons:** Treatment nonadherence, Follow-up nonadherence, Office policy nonadherence, Verbal abuse and Nonpayment.

- **Office visits:** At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require **multiple visits.**

- **Health Care Services Agreement:** I understand that I will be responsible for any additional costs to collect my past dated account, but also any additional cost that may incur for the collection of my account, such as (interest, litigation cost and attorney's fees) if so necessary.

By signing below, you acknowledge having read, understood and are in agreement with the information and expectations.
The practice may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form.

Signature of Patient: ____________________________________ **Date:** __________________