

**FLI Patient Information Acknowledgment Form**

I understand that if I have to make a payment I must bring cash, check or money order as FLI does not accept credit or debit cards. INITIAL \_\_\_\_\_

I understand that I must check with my insurance company because I'll need either a written script from my primary care physician or a referral authorization before seeing Dr. Ziajka. **If I do not have proper authorization to see Dr. Ziajka, I personally will be liable for the full office charge.** INITIAL \_\_\_\_\_

I understand *I am responsible* for payment for services provided to me, should my insurance carrier not pay all or a portion of each visits' charges. If my insurance company denies payment for any reason (e.g. un-met deductible, non-covered services, failure to secure written referral from Primary Care Physician) *I will pay* for services upon written/verbal notice of refusal from Florida Lipid Institute. Failure to pay within 30 days of notification may result in dismissal from this office. In the event I do not pay for the medical services that were provided to me, I agree to pay the cost of collection, including attorney fees, whether or not a lawsuit commenced as part of the collection process. INITIAL \_\_\_\_\_

I authorize the Florida Lipid Institute to release all information concerning my medical condition for the purpose of processing a claim. This authorization and assignment shall be valid until I notify the Florida Lipid Institute in writing of cancellation. A photocopy of this authorization shall be as valid as the original copy. INITIAL \_\_\_\_\_

I authorize my insurance carrier, attorney or any third-party payor to pay directly to the Florida Lipid Institute all charges submitted for services rendered me by the Florida Lipid Institute. INITIAL \_\_\_\_\_

I understand that if I am placed on medication and need more, I must allow 48 hours for the prescription refill to be called into the pharmacy. INITIAL \_\_\_\_\_

I understand that if I am unable to keep my scheduled appointment time I must cancel with 24-hours advance notice to avoid a \$25 no-show fee. INITIAL \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_