Miramar Ob/Gyn

SPECIALIZING IN HIGH RISK OBSTETRICS AND GYNECOLOGIC LAPAROSCOPY
3000 SW 148 AVENUE, SUITE 114
MIRAMAR, FLORIDA 33027
T: 954.499.7944 * F: 954.538.0767

Medicare Lifetime Authorization – I certify that the information given to me in applying for payment under Title XVII of the Social
Security Act is correct. I authorize any holder of medical 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 request that the payments of authorized
benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or
authorized such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Miramar OB/GYN, LLC
Patient Initial: _____

I request this authorization also apply to all other insurance. **Patient Initial:** _____

I acknowledge that I have been given Miramar OB/GYN, LLC
I understand that if I have questions or complaints that I should contact the Facility Privacy Official.
Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative Relation to Patient (if needed)

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Payment Agreement

The Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and/or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Miramar OB/GYN, LLC all insurance or third party payments that I receive for services rendered to me immediately upon receipt. **Patient Initial:** _____