## ADVANCE DIRECTIVE NOTIFICATION

Name of patient _____ , DOB ____ /____ /_____

If you have a written advance directive, please give a copy to the Nurse or front desk person. Your advance directive will become a part of your Mid-Florida Primary Care practice record you can request that it be removed or revised at any time in writing.

Please check all of the following that apply:-
__ I do not have advance directive and do not want one at this time.
__ I have provided a copy of the following advance directive today / previously:
a) __ living will, b) __ health care surrogate, c)__ power of attorney
__ I understand that my Advance Directive will not be observed until a copy is provided to the PCP clinic.
__ I have been given an advance directive to complete, __ I request that nursing review it with me.

Acknowledgement of Receipt: My signature acknowledges my receipt of written material about advance directives from Mid-Florida Primary Care office and that I have been asked whether I have advance directives.

_____ _____
Signature of patient or person acting on behalf of the patient relationship to patient

__ Patient unable to complete this form due to medical condition

Date ____ /____ /_____ , name of person/employee _____

## Confidentiality Clause

I authorize the verbal or written release of my information and test results in the event that I am not available to –
__ Person(s), please list name and relationship to whom it may be released (including family members especially spouse or immediate family members)
__ Telephone/answering machine/voice mail
__ Do not discuss results with any one other than myself

Name and signature of patient _____ ,date ____ /____ /_____

## Consent for Treatment and Payment

I hereby give consent to the practitioner of Mid-Florida Primary Care to provide whatever treatment practitioner may deem necessary to the above named patient. I understand I am responsible for payment of services provided to me including the responsibility for charges not covered by the insurance policy, and fee incurred from collection process if initiated. I hereby assign my insurance benefits to be paid to Mid-Florida Primary Care for professional practitioners fees. I hereby request payment of authorized Medicare, Medigap and/or any other insurance benefits to be made either to me or on my behalf to Mid-Florida Primary Care for any services provided to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the cliam. If item 9 of the HCFA-1500 claim form is completed, my signature, authorize releasing of the information to the insurer or agency shown. In Medicare, assigned cases, the physician or practitioner agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient or responsible party_____ , Date ____ /____ /_____